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THE UNIVERSITY OF ALBERTA

THE EXPERIENCE OF MOTHERS CONSENTING FOR DAUGHTERS' ABORTIONS

by

JUDY RAE NORRIS

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF MASTER OF SCIENCE

IN

FAMILY STUDIES

FACULTY OF HOME ECONOMICS

EDMONTON, ALBERTA

FALL, 1986

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Abstract

Qualitative descriptive inductive methods were employed to explore the previously undescribed experience of mothers who consent for their minor adolescent daughters' abortions. A convenience sample of thirteen mothers who accompanied their daughters to the host institution was studied using unstructured tape-recorded telephone interviews. The verbatim transcribed interview data were sorted into themes from which categories and concepts were derived and linkages identified, providing an integrating conceptual framework of factors which described the social-psychological process by which these informants managed the problem of their daughters' unwanted pregnancies. The experience of consenting for daughters' abortions was found to be part of a lengthy four-stage process in which mothers take responsibility for daughters' sexual socialization. Their experience of the abortion itself fit well within Adler's (1979) Social-Psychological Framework for Abortion. Evidence of the potential for maternal influence on outcomes of daughters' sexual behavior implied that primary prevention of unwanted adolescent pregnancy is best approached from developmental and interactional perspectives.

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In acknowledging the contributions of others, I begin with grateful appreciation to the thirteen women who participated in this research. Their generosity in giving their time to share their experience, feelings, and insights with me made possible an initial understanding of how an adolescent's abortion is experienced within the family. Each woman participated with the hope that her contribution would ultimately benefit others.

To my supervisor, Dr. F.J. Morrison, co-supervisor, Dr. J.M. Morse, and committee member, Dr. N. Keating, I wish to express gratitude for so patiently guiding and supporting me throughout the project, especially when I became 'stuck' in yet another stage. I am deeply indebted to Dr. Morse who introduced me to Grounded Theory and shared with me the joy of discovery.

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I. INTRODUCTION

The problem of adolescent pregnancy is extensive. Tauer (1983) cites data from a 1981 report by the Allen Guttmacher Institute to define the scope of the problem:

> If current trends continue, of today's 14-year old girls, four of every ten will have at least one pregnancy, two of every ten will have at least one birth, and more than one of every seven will have at least one abortion while still in their teens (p. 722).

Bryan-Logan & Dancy (1974) state that an unwed adolescent's pregnancy is experienced as a crisis by the entire family, but especially by the mother. These authors, as well as Barglow, Bornstein, Exum, Wright and Visotsky (1968) and Smith (1975) note that both mother and daughter experience shame, guilt and upset. Bryan-Logan & Dancy (1974) observed that a mother may view a daughter's adolescent pregnancy as a sign of her own inadequacy as a parent, and is therefore, ready to accept some blame for the situation.

The paucity of literature describing the experience of a mother dealing with her adolescent daughter's pregnancy is noted by Smith (1975) and Bryan-Logan & Dancy (1974). More recently, Rosen, Benson & Stack (1982) reviewed the literature to discover only passing reference to parents in studies of adolescent pregnancy resolution. Additionally, there is only anecdotal evidence (Liebman & Zimmer, 1979) to suggest that mothers may be affected by their daughters' abortions.

In Canada, in 1982, 1,679 girls under the age of 16 had therapeutic abortions (Statistics Canada, 1984). Each of these girls (unless they were married or otherwise emancipated), required the consent of a parent or guardian for the procedure. Studies addressing the issue of parental involvement in pregnancy resolution decision-making (Rosen, 1980; Rosen et al., 1982) have shown that the mother is almost always the parent that participates in and implements an abortion decision for adolescent minors. It can be argued therefore, that adolescent pregnancy resolution by abortion is often a dyadic experience with potential for disrupting the lives of both mother and daughter, yet virtually nothing is known about the mother's experience.

The dyadic nature of the abortion experience for adolescent minors has gone unrecognized by nursing and other helping professions. Beeman (1985) has demonstrated the need to include support persons such as parents in abortion counseling, so that these individuals might be better equipped to provide a more supportive environment for the abortion client. Bracken, Hachomovitch & Grossman's (1974) study showed that parental support was a powerful predictor for favorable reaction to abortion among young women. By identifying and meeting the needs of mothers consenting for daughters' abortions (MCFDAs), professionals could better equip them to support their daughters, thus enhancing abortion outcomes. Clearly, then, there is justification for investigation into the experience of MCFDAs in order that

increased knowledge and awareness might improve care delivery to these dyads. Additionally, there exists a need to begin a literature to which others can contribute; at present, there is no theoretical coverage of abortion as experienced within the context of the family.

A. Statement of the Problem

The purpose of the study was to begin investigation into the experience of mothers who consent for daughters' abortions. The research questions were:

1. What are the factors which describe the social-psychological process in the experience of mothers who consent for their daughters' abortions?
2. What are the implications for nursing, and other helping professions, for care delivery to mother-daughter dyads sharing the experience of resolving an unwanted adolescent pregnancy by abortion?

B. Definitions and Assumptions of the Study

1. An induced abortion is defined as the deliberate termination of a pregnancy. All abortions referred to in this study were induced. The gestation period at the time of the abortion was less than twelve weeks for all but one daughter, whose pregnancy was terminated in the thirteenth week. The procedure of choice at the host institution for this gestational age, is dilatation and evacuation, usually with prior insertion of laminaria

(dried stems of a type of seaweed) to dilate the cervix.

2. A mother is defined either as the biological mother of the daughter, or the adoptive (but not foster or step) mother of the daughter.
3. A daughter is a pregnant adolescent presenting for a therapeutic abortion, and who, because she has not attained the age of majority, or is not otherwise emancipated, must obtain a parent or guardian's consent to undergo the procedure.

II. SURVEY OF THE LITERATURE

Because there is only anecdotal evidence in the literature pertaining to mothers' experience with their daughters' abortions, it is necessary to survey instead, related abortion and adolescent pregnancy literature. The first section of the chapter will address emotional response to abortion deriving from social and psychological variables, followed by an overview of the process by which women make the decision to resolve an unwanted pregnancy by abortion, and the involvement of mothers in adolescent pregnancy resolution decision-making. Finally, Adler's (1979) Social-Psychological Framework for abortion is reviewed.

A. Emotional Response to Abortion

Two authors who reviewed the abortion literature which was written prior to 1966 (Adler, 1975; Zimmerman, 1977), concluded that most of it was based on studies of psychiatric patients, was methodologically faulty, and reflected the ideological bias of the day: that women seeking abortion were, *ipso facto*, maladjusted. Zimmerman (1977) states that almost all conclusions reached were that long-term psychiatric sequelae were the inevitable result of abortion. The more recent studies, among them Osofsky & Osofsky (1972), and Senay (1970) conclude infrequent severe negative reaction, or as Adler (1975) states in her review, "mild to moderate feelings of guilt, regret or remorse" (p.

447), which diminish over time. Niswander & Patterson (1967) and Whittington (1970) studied positive emotional response and reported that the majority of their subjects reported happiness and relief after the procedure.

Adler (1975), who studied post-abortion emotional responses, was the first to hypothesize that a woman feeling negative emotions such as guilt or regret, might simultaneously feel positive ones like happiness and relief. The results of her research revealed that positive emotions are a separate factor, and not simply the inverse of the negative emotions. Moreover, the negative emotions were of two distinct types: a) reactions to social stigma and norm violation (shame, guilt, fear of disapproval), and b) reactions to internal psychological factors (regret, anxiety, depression, doubt, and anger).

Response to Social Stigma and Norm Violation

In Canada, abortion moved suddenly from illegal to therapeutically legal status in 1969. Zimmerman (1977) notes that "rapid social transitions leave a wake of confusion in norms and values" (p.1). Further, Merton (1968) points out that anticipatory socialization is a part of a learning process that eases role transition. Because women rarely disclose that they have had an abortion, many have not seen abortion modeled, and therefore, role-taking norms are unclear. Blake's (1973) attitude survey showed that the majority of Americans felt abortion was morally

unacceptable, but at the same time believed that abortion should be legal and available for others. Abortion in North America is something that happens to "other people" (Williams & Hendell, 1972), and is legal, but not moral. Friedman, Greenspan & Mittleman (1974) made the interesting observation that in Japan and Russia where abortion is not controversial, there is no expectation of, and little research into psychological aftereffects, while American studies on the subject are numerous.

Violation of perceived social norms can produce reactions to abortion that are distinct from those derived from internal psychological states. Adler (1975) used factor analysis to isolate response to social norm violation in a sample of seventy aborters. None of Zimmerman's (1977) sample of forty aborters perceived that their community would be approving of their abortion.

Abortion as Deviance

It has been stated that abortion is viewed in this culture as legal, but not moral. That aborters believe themselves to be deviant, and thus deserving of negative sanction is demonstrated by women's care to maintain secrecy about an abortion and their expectation of hostile and punitive reactions from others, especially staff in abortion facilities (LeRoux, 1970; Zimmerman, 1977). This fear, like expectation of social disapproval is not unrealistic. Studies investigating nurses' attitudes toward abortion have concluded that they are less in favor of abortion than are

other groups (Bourne, 1972; Werley, Ager, Rosen, & Shea, 1973; Zahourek, 1971), may exhibit strong negative reactions to abortion (Char & McDermott, 1972), and may negatively affect patients' perceptions of care quality by these attitudes (Harper, Marcom & Wall, 1972). Lindgren & Lombardo (1985) believe that nurses' anger and their failure to recognize this anger when caring for abortion clients is a great deterrent to providing therapeutic care.

Response to Internal Psychological Factors

McDonnell (1984) proposes that it is unrealistic to expect that the emotional aspects of the abortion controversy will abate, because the abortion issue "is a 'flash point', a meeting place of some of our most basic and contentious views of sexuality and reproduction" (p. 27). It is this volatile confrontation of values that inspires the ambivalence that women may feel when choosing to end an unwanted pregnancy by abortion. Adler (1975) states that internally based negative emotions are derived from a sense of loss, and may reflect a mourning process. Adler (1979) notes that women are "at least somewhat ambivalent about ending a pregnancy" (p. 113), and that the difficulty of the decision to abort (measured in this study prior to the abortion) relates significantly to internally based negative emotions, "but neither to the socially based emotions nor to the positive emotions experienced afterwards" (p. 113).

McDonnell (1984) concurs that the ambivalence theme is strong in the literature and in women's accounts of abortion, but states that it is not the decision itself that produces ambivalence, but rather "the act of abortion and its implications" (p. 30). As one of her respondents stated: "the decision to have an abortion itself wasn't hard. It's hard reconciling the feelings after the decision" (p. 30). Adler (1979) linked regret with a mourning process, but McDonnell (1984) cautions that a distinction must be made between grief and regret, for they are not the same. As illustration, she cites "Heather's" statement:

> It was still the right decision at the time. But I still had to cry, to grieve the loss of this potential child, and the loss of my pregnant state. (p. 35)

This distinction is necessary in understanding women's thought and subsequent emotional response to abortion because the choice in abortion, as perceived by women, is a choice between self and other:

> Like no other dilemma that women face, abortion pits our desire to care for others, to protect others and avoid hurting them into stark and seemingly irreconcilable conflict with our desire to protect and take care of ourselves, to act in our self-interest. (McDonnell, 1984, p. 30)

B. The Fetus as a Component of the Context

Because women's morality tends to be rooted in human relationships (McDonnell, 1984), pregnancy precipitates an inspection of all salient patterns of interaction, those past and present as well as those expected in the future.

Seen in this light, it becomes clear that choice in pregnancy resolution involves not the unidimensional consideration of maternal versus fetal rights (McDonnell, 1984), but rather the interdependence between the two entities as judged within the context of a nexus of other relationships. Gilligan (1982) explains the enormity of the abortion decision:

> As pregnancy signifies a connection of the greatest magnitude in terms of responsibility, so abortion poses a dilemma in which there is no way of acting without consequences to other and self. In underlining the reality of interdependence and the irrevocability of choice, the abortion dilemma magnifies the issues of responsibility and care that derive from the fact of relationship. (p. 108)

All but 15 percent of Zimmerman's (1977) sample of aborters defined the fetus as a person or a human life, nearly 25 percent stated that abortion constitutes an act of killing a life, a baby, or a person, while another 25 percent grappled with their inability to come to terms with the question of the fetus. Cathecting the fetus, that is, fantasizing about its appearance, sex, or ascribing to it roles such as grandchild, and being aware of the due date, is associated with sense of loss and sadness in several studies, among them Friedman, Greenspan & Mittleman (1974) and Cobliner, et al., (1973).

C. Mothers' Involvement in Decision-Making

Regarding abortion decision-making, Smetana (1982) states that

> women weigh their beliefs about significant others'

> expectations regarding their unwanted pregnancies against their beliefs about the consequences that might result from either having an abortion or having the child. These beliefs produce their attitudes toward abortion, and these, in turn, predict whether or not they will decide to have an abortion. (p. 6)

Vacillation or ambivalence in the decision to resolve one's own pregnancy by abortion is associated with sense of loss (Adler, 1975), subsequent unwanted pregnancy (Brown, 1983), emotional difficulties (Friedman et al., 1974), and mental anguish (Zimmerman, 1977). A host of sociological and psychological factors can affect autonomous pregnancy resolution decision-making, reducing the clarity of that process, but the dilemma of the MCFDA is complicated by additional considerations. Brown (1983) notes that an early adolescent with little autonomous experience is poorly equipped to cope with ambivalence, and may remove herself entirely from the decision-making process or comply passively with parental wishes. Cobliner, Schulman & Romney (1973) have observed the tendency for some adolescents to bypass conflict resolution by having others assume responsibility for the abortion. Young adolescents often regress toward a more dependent state in crisis. Mercer (1979) cites Schaffer & Pine who observed that "the girl who regressed allowed her mother to discover the pregnancy and to make the decision for the abortion; she remained passively mothered" (p. 259). More than half of the minors that Rosen (1980) studied, involved their mothers in pregnancy resolution decision-making. This phenomenon was

also demonstrated by Brashear (1973) and Shaffer & Pine (1972), especially among mother-identified and inexperienced girls. Rosen et al. (1982) observe that most adolescents live with parents whose power and resources must affect abortion decisions.

Bryan-Logan & Dancy (1974) illustrate the mother's dilemma: costs of child-bearing to her daughter's physical and psychological health, economic well-being, and life options (Arnold & Hoffman, 1974; DeLissovoy, 1973; Johnson, 1974), and her own possible reluctance to assume care of a grandchild (Bryan-Logan & Dancy, 1974; Smith, 1975) may be weighed against strong moral opposition to abortion. Several studies have shown that mothers influencing daughters in resolution decisions urged abortion (Fischman, 1977; Kimball, 1970; Zimmerman, 1977). Adolescent perception of parental coercion to abort is, however, associated with daughters' negative post-abortion reactions (Barglow & Weinstein, 1973; Bracken, Klerman & Bracken, 1978).

Mothers appear to be actively involved in pregnancy resolution decision-making. The mother may find herself in a paradoxical situation: she must effect the resolution decision while the abortion option is open, but not coerce a daughter who may be denying the pregnancy, abdicating responsibility for pregnancy outcome, or opting out of the decision-making. Freeman (1977) asserts that those who choose abortion are agents who vigorously intervene to "deny passive acceptance of an unwanted pregnancy" (p. 510).

MCFDAs then, can be seen to be agents acting in a vastly more complex context than are women making decisions for their own abortions.

D. Definition of the Situation

An individual's definition of the situation is the "system-being-itself" (Dell, 1982, p.31). The definition may be erroneous, but nevertheless, constitutes the perceived real world (Hansen & Hill, 1964). Given the social context pertaining to abortion in this culture, it is likely that a MCFDA socialized amid the white heat of the North American abortion controversy will consider a daughter's abortion experience to be an extraordinary occurrence. Adler (1979) offers a social-psychological framework for abortion, and states that because there is no stress-free solution to an unwanted pregnancy, it is logical to deal with abortion from within a crisis framework. The extent of the crisis is a function of certain social and psychological variables, and the resources the woman brings to the situation. Social variables include norms and values, the extent to which the abortion is the woman's own choice, the degree of support by significant others, and the abortion environment. Psychological variables reflect abortion attitudes, a consideration of relationships with significant others, the meaning of the pregnancy, and the reasons for termination. It follows then, that the MCFDA's definition of the situation, of the degree to which it is a crisis, and to

which her choice to act as her daughter's agent in consenting for the abortion, places her world image, her 'self', in an incongruent relationship with reality, will determine the variable cognitive work needed to reconcile the abortion with the existing self-structure.

III. METHODOLOGY

A. Theory Development

A theory is a conjectural organizing statement about concepts and their proposed relationships in the empirical world. The function of theory is to interpret, explain, predict and/or guide action in relation to a phenomenon or problem (Chenitz & Swanson, 1986; Field & Morse, 1985). Dickoff and James (1968) state that research in practice disciplines should ultimately produce theory for professional purpose, but that this prescriptive theory for application to practice presupposes the existence of three more elemental levels of theory. The most basic of these, factor-isolating theory, is described by Field & Morse (1985), who draw from the work of Diers (1979), as resulting from studies which are "descriptive in nature and occur at the exploratory or formulative stage of theory development" (p. 9). Since virtually nothing is known about the experience of MCFDAs, an inductive, exploratory design was appropriate for this seminal research.

The study utilized the Grounded Theory discovery model (Glaser, 1978; Glaser & Strauss, 1967) as the approach to the research problems. This systematic method for collection and analysis of qualitative data is a research process for the purpose of theory generation. Use of this method resulted in identification of those process variables (factors) which describe most of the social-psychological

variation in the experience of MCFDAs. Further analysis at the next theoretical level, that of factor-relating, (Dickoff & James, 1968; Diers, 1979) sought to discover linkages or relationships among the factors. These connections provided the structural framework for the emerging theory.

As Grounded Theory is inductive, there are no prior hypotheses nor conceptual/theoretical frameworks used to initially guide the investigation. Rather than attempting to square the data with a pre-existing theory, the researcher is freed to remain open to the actual experience of the informants. Grounded Theory does, however, assume a symbolic interaction perspective to study human behavior and interaction (Chenitz & Swanson, 1986). As the goal of this inquiry is to discover the unique, personal reality of a mother's perception of her experience in consenting for her daughter's abortion, this study will assume a symbolic interactionist persepective.

B. Symbolic Interaction Theory

In this approach, the MCFDA is regarded as a woman with a 'self' acquired through interaction with significant others, who eventually become generalized others, whose perspective she uses to see 'self', judge 'self', analyze situations, and act in a complex, unpredictable manner (Charon, 1979, p. 80). Action to an interactionist is both covert and overt. It means

> understanding the manner in which people come to define situations, how they develop and use perspectives, change perspectives, roletake, problem solve, converse with self, and decide on a line of action. Understanding covert behavior involves studying mind as action rather than mind as content. (Charon, 1979, p. 178)

Stryker & Serpe (1982) assert that an interactionist perspective directs the researcher to regard the 'self' as the product of society, and the key conceptual variable in the explanation of social behavior. Stryker (1968) sees "the self as composed of differentiated identities [that] exist in a hierarchy of salience" (p. 561). As the internal component of a role, an identity is relational to other identities and thus to other roles (Burke, 1980; Mead, 1934).

If a salience hierarchy implies choice-making among role-identities, and if reciprocity of society and self is a tenet of interactionism, then, because neither society nor the individual operate in stasis, conflict or incongruities must be the inevitable result of their interface. Furthermore, the interface of self and role can result in incongruence. Sarbin & Allen (1968) state that

> [t]he role may require behavior which is regarded as wrong, improper, immoral, or unbecoming to one's self system. Such extreme incongruence between values or beliefs about self and role expectations creates severe psychological effects on the individual . . . (p. 524)

The MCFDA, therefore, was regarded as a woman whose 'self' has been acquired in social interaction. Within this self are hierarchical role identities, and choices made in

invoking them may be incongruent with society and/or self. A mother, choosing the role of MCFDA may find this identity to be incongruent with her self and/or social environment, yet assume it to assist her daughter in the resolution of an unwanted pregnancy.

C. Grounded Theory

The researcher using this method approaches the phenomenon to be observed with as few preconceived ideas as possible. The objective is to discover the emic perspective, that is, the real experience of the situation from the informants' viewpoint. Data obtained in this manner are valid to the world from which they emerged. Moreover, low inference descriptors (verbatim accounts) are considered credible (Field & Morse, 1985). Generalizability was not the purpose of this study; rather, the intent was to identify those factors which described most of the social-psychological process in the experience of MCFDAs. From these factors, testable hypotheses were generated. These can be subjected to empirical testing with other populations to extend the theory or revise it.

As data were gathered, categories became apparent, and later, clusterings and linkages emerged, providing an integrating framework. The resultant theory is grounded in the data and as such has fit and relevance. Grounded theory also *works*, that is, it is useful to explain what happened, predict what will happen and interpret what is happening in

the area of inquiry (Glaser, 1978). Moreover, and pertinent to a specific goal of this study, Grounded Theory can guide future research in the area.

D. Data Collection Methods

The Sample

A convenience sample of thirteen MCFDAs who accompanied their daughters to the host institution, and who agreed to participate in the study, was chosen. To avoid introducing extraneous variables and the possibility of legal implications, mothers whose daughters were pregnant as the result of rape or incest were excluded from the sample.

The women were English-speaking Caucasian Canadians, and ranged from 32 to 52 years of age. Eight were married, and were living with the daughters' fathers, two were widowed and living alone with their children, one was remarried and living with her husband who was not the daughter's father, and two were separated or divorced. One of these mothers lived alone with her daughter, while the other lived alone; her daughter residing with the father. All of the mothers except four had employment outside the home. The daughters ranged in age from 14 to 17 years. Eleven of the girls were the biological daughters of their mothers, while two had been adopted as infants. All but two were attending school.

Data pertaining to the socio-economic status, religiosity, or educational attainment of the mothers were not obtained. Concurring with Hatcher (1973), the researcher rejected "the contradictory conclusions of a previous literature in the field which suggest that illegitimate pregnancy is a consequence of demographic factors, idiosyncratic family constellations, or neurotic conditions" (p. 54). Johnson (1974) also reviewed this literature, and noted that pregnancy was explained by psychological factors for white girls, and sociological factors for blacks. For this research, the position is taken that adolescent pregnancy relates to adolescent sexual behavior, is best understood from a stage-specific adolescent developmental paradigm (Hatcher, 1973; Hatcher, 1976), and that there is, therefore, little explanatory power in correlates with maternal or family demographic variables.

The Site

The host institution was a large, urban general hospital in which therapeutic abortions are performed after approval by a Therapeutic Abortion Committee (TAC).

The Procedure

All daughters were admitted to the hospital as day patients at 06:00 on weekdays. The mothers accompanied them to the unit, and signed the consent as part of the admission procedure. Because many mothers left the hospital at this

point to go to work or see other children off to school, the nurse responsible for the daughter's care introduced the mother to the researcher at this time. The researcher then took the mother to a private room where the project was explained and the mother invited to participate. Those who met the criteria for the sample and who expressed interest were given an introductory letter, and a tentative time for the first interview was agreed upon. As all interviews were conducted by telephone, the researcher had no face-to-face contact with the informants after this short meeting, and to preserve anonymity, only first names and telephone numbers were retained.

At the time scheduled for the first interview, the researcher placed a call to the MCFDA, reminding her of the tentative appointment, and asking her if she was available for an interview then, and if she could talk privately. If these conditions were met, the research project was explained in detail, and a tape-recorded informed consent was obtained to conduct tape-recorded telephone interviews. The tape used to record the consent was separate from those used to record data.

Because of the absence of theory in the area of inquiry, it was appropriate to use unstructured interviews with the initial informants. The researcher asked each mother to describe her family life, and then to tell the story of the event in chronological order, and did not interrupt until the story was finished. Notes taken during

the interview were used as prompts to clarify areas, fill gaps in the data, and elicit feelings. The same procedure was used with all informants, but those interviewed later were asked to verify emerging concepts after telling their own story. They were asked, "Some mothers have said [example]; was it like that for you?" This test-retest procedure adds to the reliability of the data, is a search for the different case, and keeps the researcher on track. MCFDAs are the only experts in the area under study, and were quick to confirm or deny the concepts the researcher inquired about.

The original research design called for at least two, and ideally three interviews with each MCFDA. This strategy was abandoned with regret after the first six informants' second interviews yielded no worthwhile data. It was as if there had been a 'grand catharsis' in the first interview, and having told the story, the informants considered the issue closed. It was deemed necessary to accept this constraint.

While hour-long interviews were initially considered to be most desirable, most mothers talked for approximately ninety minutes. 'Talking out' the abortion experience in a non-threatening situation was stated to have been a therapeutic experience for the informants, and they appreciated the opportunity to tell their stories, and to perhaps help other women by doing so. The shortest interview was approximately forty minutes, while the longest ran over

two hours.

The researcher commenced the project with few interviewing skills, with the result that interview data obtained from the first three informants were used sparingly, since they had been obtained mainly by direct, and sometimes close-ended questioning. As skills increased, the data became more rich, flowing spontaneously from the informants themselves, without interviewer interference. A characteristic pattern was evident in most of the interviews; interviewees began tentatively, not knowing what would be expected of them, but relaxed as they realized they were simply being asked to relate their stories in an anonymous, confidential, and non-threatening environment. At that point, the story of their experience poured forth rapidly, and informants became annoyed if the researcher interrupted to clarify points. Then, when the story was finished, the informants seemed to need a release of pent-up emotions; this was achieved through laughter or tears. It was encouraging that most interviews concluded with the informant thanking the researcher for the opportunity to relate her experience.

Data Analysis

In Grounded Theory, analysis is ongoing with data collection. The constant comparative method (Glaser & Strauss, 1967; Glaser, 1978) was used firstly to compare incident to incident for uniformity and concept formation,

and secondly to compare concepts to further incidents. Tapes were transcribed verbatim by the researcher and data were sorted into themes for each informant. From these themes, categories were developed which eventually became integrated into substantive theory valid for this group of informants.

Risks and Benefits to Informants

Although literature exists describing the therapeutic benefits of 'talking out' an abortion experience (McDonnell, 1984), it was deemed necessary to consider that by participating in interviews about this sensitive topic, the informants might have been placed in a situation with potential risk for emotional trauma. Fortunately, the interview process proved to be a benefit, rather than a risk to the informants' emotional state. McDonnell (1984) states that the talking-out process is crucial to working through an abortion experience, and that the listener need only be a friend. This phenomenon was confirmed by the informants. For verbatim examples, see the section in chapter five describing the informants' response to the study.

To increase the likelihood that the informants would benefit from having participated in this study, at the close of the interview, each woman was given information about cost-free post-abortion counseling services in the area, that she or other family members could make use of, if they so desired. Selected books were recommended to some mothers who expressed a desire to learn more about other women's

abortion experiences.

Ethical Considerations

Confidentiality

This was assured by the following methods:

1. Transcription of tapes was done by the researcher, and these tapes were kept in a locked file until erased at the conclusion of the study.
2. A code number was assigned to each informant. The sole identifiers, informants' first names and telephone numbers, were known only to the researcher, and these were destroyed at the conclusion of each woman's interviews.
3. When reporting the data, identifying characteristics of informants, their families, and geographical locations were deleted or altered to preserve anonymity.

Ethical clearance

Ethical clearance was obtained from the Ethical Review Committees of the University of Alberta and the host institution.

Debriefing mechanism

As the informants were fully aware of the research intent and methodology, this awareness constituted the debriefing mechanism. Additionally, informants were offered the opportunity to ask questions about the study at any time, and to receive a summary of the results.

IV. RESULTS AND DISCUSSION: PRE-PREGNANCY AND PREGNANCY PERIODS

In this chapter, the first portion of the results of the study will be presented. The data were comprised of four major topic areas. The informants addressed issues pertaining to: a) events prior to the pregnancy, b) the pregnancy, c) the abortion, and d) events after the abortion. From each of these large categories, several smaller substantive areas emerged. Data from the first two major categories will be reported in this chapter, and the latter two in the succeeding one. The analysis will be illustrated with examples of similarities and differences in the verbatim statements of the informants. To protect anonymity, identifying characteristics have been removed or altered.

Following the reports of each major section of the data, the concepts emerging from the these data were examined in the light of relevant extant literature, not for the purpose of verification, but rather for comparison, idea generation, and conceptual guidance (Glaser, 1978). Finally, factors isolated from these data were related to others, and these relations declared in the form of directional, testable hypotheses.

A. Events Prior to the Pregnancy

Informants were asked by the researcher to tell their story in chronological order, beginning at whichever point they wished. Almost all the mothers began the interview with background information pertaining to the daughters' sexual activity and contraceptive efforts. Most discussed the supportive-educative role they had assumed in pregnancy prevention and finally, the observations that led them to suspect their daughters' pregnancies.

Assessing Sexual Activity and Contraceptive Effort

Mothers were sensitive to indicators that their daughters were sexually active and sought information about this as well as the daughters' contraceptive efforts:

> ...well, what made us think about it was that she had a hickey on her neck, and I'd noticed this when we were in [city] at Christmas time. So then, I thought: gee, you know, we'd better sit down and talk; this looks like it's getting heavy. So when we got home, we discussed it, and we point blankly asked her if she was having sexual relations, and she admitted it, and so then we asked her what she was doing to prevent pregnancy...

> I think that I was quite aware of the fact that she was sleeping with him when it happened, and I talked to her about it, and at that time she assured me that she was using some means of birth control, but she didn't want to talk about it in very much detail, it was sort of, "Oh, mother, I know what I'm doing", sort of reaction.

Being Open in Talking About Sexual Topics

Most of the mothers stated that they had been open in discussing sexual topics with their daughters, and had

assumed a supportive-educative role in pregnancy prevention. Some expressed their frustration that despite efforts to give information, the daughters were often resistant to discussions of such an intimate nature, and either did not absorb the information given, or had not applied it:

> ...I said, "Well, [daughter], we're going to talk this out even though it is embarrassing for you perhaps. I've got things that I want to say". And she'd say, "Yeah, yeah, yeah", and she'd let me go ahead and say these things [about birth control], but it's an 'I know better' attitude. And they <u>don't</u> ...they are not nearly as well educated as they think. I was really surprised.
>
> I have a fairly up-to-date attitude about premarital sex. We were just surprised to find out how poorly educated she actually was about the whole thing, and that surprised me because after all the talks we've had...it really surprised me. Can you tie them to a chair and make them listen?
>
> You know, it is so amazing that you can give the information and in fact, in my case I insisted that the information be there, and yet it [pregnancy] happened.

Only one daughter in this study approached her mother to discuss contraceptives:

> ...she said, "Mom, I've been going out with him for six months and sometimes things get a bit tense, and I think I should go to the doctor and get the pill or something, because I don't want to take a chance". And I said, "Fine...that's the attitude you should have, go talk to Dr._".

Regret was expressed by some mothers that they had not addressed the contraceptive issue early enough, that they had not been more assertive, or that they had accepted false indicators that pregnancy would not occur:

> I felt really badly that I hadn't talked to her about the pill, which I had promised myself over the years that I would do if I had a daughter, ...but you don't realize how fast they grow up.

> ...she said, well, they were using a condom. But she didn't say, 'sometimes' to me, she said they'd been using it, so I said, well, everything was okay, you know...sort of hoping it was quite safe.

A conflict was experienced by some mothers about advocating contraception when they believed that their daughters were too young for sexual activity.

> So many times I wanted to go into her room, you know, and say, "Can we talk? Can we talk about birth control?", but then I'd think: No, she's too young. And she wasn't. That's something I regret. But birth control; it's like saying, well, I give you my blessing.

> Too bad they're starting [sexual activity] too young. Like, this happened with our daughter...we told her to talk to us...to come to us when she thought that maybe it was time to get on the pill, eh, like before things went any further with her boyfriend, but she also knew that we thought she was too young to get into any sexual activity.

The daughter in the latter example can be seen to have been put in a double-bind, or at least, an untenable position.

Suspecting Pregnancy

Many of the mothers were sensitive to changes in their daughters, either emotional or physical. They noticed the absence of menstruation, and linked symptoms such as the vomiting of morning sickness, tiredness, or changes in body shape to the possibility of pregnancy:

> So then, I noticed, right, that there was no tampons missing and I kept asking her, "Have you got your period yet?", and she said, "No"... I bought a home pregnancy test downtown and we had done that and it showed it negative, so I figured that maybe she's just 'off'. I was, too, when I was very young...I'd get them every three months when I was 13, 14, 15, and so since I wasn't very regular, I thought that

> she's the same thing, but what really seriously made me think that she may be pregnant was around the first part of February, and I noticed that she wasn't interested in going out anymore. At night she was so tired that she was going to sleep before her time. And, she complained that her bras weren't fitting her properly and were too tight...you know, some of the symptoms, so that's when I really started seriously thinking about it, and then nothing was coming as far as the periods and she saw the doctor.
>
> ...I've kept this to myself, but being a mother who washes her daughters' clothes, I do know when they have their monthlies. And I noticed that [daughter] didn't have anything on her clothes. It flashed through my mind...I certainly didn't want to believe it.

Discussion of Findings

The mothers in this study indicated that they had taken some responsibility for preventing daughters' pregnancies by employing two strategies, informing and being vigilant.

Informing

While the results of several studies (Bloch, 1972; Herold, 1981; Herold & Goodwin, 1980) indicated that adolescents considered their mothers to have been a poor source of information about sexual topics and contraception, most of the mothers in this sample related their frustrations with attempts to impart information to daughters who were resistant to the discussions. This is consistent with the findings of Hatcher (1976) whose data suggest that early adolescents (defined as age 12 to 15 years in her study) protect themselves by a great deal of defensive denial, and are therefore not very receptive to

the "facts of life". She concludes that sex education is effective only when there is sufficient emotional maturity to absorb the information. Some mothers regretted having backed down when the girls became embarrassed, protested that their privacy was being invaded, or stated that they "knew what they were doing". Greer (1985) asserts that adolescents resent parental attempts at sex education because if they are taught how to do it, then "[t]heir sexuality is given up to the scrutiny of the elder generation and the excitement is lost" (p. 216).

Herold (1984) states that adolescents are concerned with keeping information about their sexual and contraceptive activities hidden from parents because they believe parents would disapprove of their having intercourse. They are probably correct, for as Reiss (1973) found, women become measurably less permissive in their attitudes about premarital sexual behavior as their daughters reach puberty. Additionally, Marsman (1983) reported that 61 percent of mothers in her Canadian study disapproved of premarital sex for 18-year-olds who were in love. In the present study, two of the mothers explicitly stated their ambivalence about condoning contraception when they felt their daughters were too young to be sexually active. If in fact, the mothers had directly or by message character, communicated their disapproval of premarital sexual activity, and as several mothers related, had then directed the girls to come to them for assistance with

accessing contraceptive methods when they became sexually active, the daughters were put in an untenable position. As Lindemann (1974) stated:

> A girl cannot readily ask her parents about birth control. They are usually ambivalent about, if not downright opposed to premarital sex. Even in families that have a permissive attitude toward premarital sex, parents are not able to help their daughters plan for birth control in concrete terms. (p. 29)

Herold (1984) states that in his research, 72 percent of the sexually experienced females had not told their parents about having had intercourse. Fox (1980) reviewed the literature on mother-daughter communication about sex which suggests that what communication there is seems to be limited to attempts to discourage daughters' sexual activity and to promote better contraceptive practice. Further, he notes that it is plausible that daughters talk to their mothers about contraception only after they become sexually active, have begun to use contraceptives, or have had a pregnancy scare.

Only one daughter in this study approached her mother to obtain contraceptive advice, in the other families where this issue was discussed it was the <u>mother</u> who actively sought evidence of her daughter's sexual activity and contraceptive effort, who then attempted to inform the daughter about contraceptives, and in some cases, to assist her to access them. This finding is in contrast to the literature which proposes that there is little mother-daughter communication about sexual topics until the

daughter discloses that she is sexually active and in need of contraceptives. Most mothers in this study, aware that adolescent daughters would be unlikely to make such a revelation, took responsibility to assess the situation and to intervene to prevent pregnancy, regardless of their attitudes toward daughters' premarital sexual activity. Pregnancy prevention was the salient concern. This is consistent with Furstenberg's (1970) finding that mothers of over 90 percent of a sample of sexually active girls wanted their daughters to use contraceptives, and Reiss' (1973) thesis that at puberty, mothers have a heightened sense of responsibility for the sexual behavior of their daughters.

Bernard (1975) suggests that some mothers have adopted an "ostrich response" to their daughters sexual behavior, that is, they protect themselves from knowledge of their daughters' sexual behavior while passively hoping they would refrain from becoming pregnant. The phenomenon was demonstrated by a small minority of mothers in the present study who stated that they had never thought of their daughters as being sexually active, and had therefore, not discussed contraception with them in a situation-specific way. In Herold & Way's (1983) study, daughters stated that they had discussed premarital sex (80 percent) and contraception (70 percent) with their mothers, however the discussions were on a general level with the personal details of the daughters' sexual behavior omitted. This was not the case in the present study; those mothers who

discussed premarital sex and contraception with their daughters, applied their teaching specifically to the daughters' sexual behavior. Only those who were seemingly unaware of their daughters' sexual activity discussed these matters in general terms.

All daughters in the present study became pregnant as the result of unprotected intercourse. Parental variables such as perceived support of an adolescent female's decision to use a contraceptive method (Jorgensen & Sonstegard, 1984), and accompanying the adolescent to the birth control clinic (Scher, Emans, & Grace, 1982) were found to be predictors of more consistent contraceptive behavior in adolescents in these two studies. While many of the mothers had supported the use of contraception, only one mother in this study stated that she had accompanied her daughter to the family physician specifically to obtain contraceptives, where when examined, the daughter was found to be pregnant. Two mothers advised family physicians that their daughters had permission to obtain contraceptives, while the others who discussed this topic delegated the responsibility to the daughter to access a contraceptive method.

The informants expressed incredulity that having informed their daughters about contraceptives and having advocated its use, that the daughters became pregnant while engaging in unprotected intercourse. This may have been a function of not understanding the psychological costs of contracepting for adolescents. Herold (1984) states that an

adolescent may not have accepted the idea that she is sexually involved, so would prefer to be emotionally carried away, and thus not responsible. Further, he states that some young women identify contraceptive preparedness with promiscuity. Tauer (1983) notes that egocentrism is a characteristic of adolescence which leads the adolescent to believe that she is not subject to the same rules as everyone else, and is therefore magically protected from getting pregnant. Kandell (1979) states that adolescents are idealistic, and believe that sex should be spontaneous, sincere, passionate and beautiful, an attitude which is inconsistent with contraceptive preparedness. Polsby (1974) contended that adolescents get pregnant when contraceptives are available because they are not mature people. She states that maturity is required for a person to exercise self-control, foresee the consequences of behavior, believe she can get pregnant, and have the nerve to acknowledge her sexuality to a doctor.

In the present study, one daughter used condoms sometimes, one was taking the birth control pill irregularly, three had prescriptions for the pill, but had quit taking it, while the other eight were not using contraceptives. Expert witnesses testifying at the 1978 House of Representatives Select Committee on Population (Greer, 1985) stated that the pill was not suitable in the context of the irregular sexual activity characteristic of the adolescent. Youngs & Niebyl (1975) note that a common

clinical problem is the adolescent who presents with an unwanted pregnancy as the result of irregular use of the birth control pill.

Being Vigilant

Fox (1980) describes the conflict of the two aspects of the mother role in a daughter's transition from child to adult, that of discerning whether to act as protector of daughter-as-child, and make decisions on her behalf, or to guide the daughter-as-woman, allowing her to find her own way and live out the consequences of her decisions. The informants in this study maneuvered along this fine line by the strategy of being vigilant. The mother in her role as protector, sought to socialize her daughter in the norms, values and expectations of the family culture in order that her life options would not be compromised by an unwanted adolescent pregnancy. This was done through the strategy of informing about sexual topics, contraception, and the consequences of adolescent pregnancy. In her role of guiding the daughter toward competence in the adult sexual role, the mother sought indicators that the daughter was assuming responsibility for her own sexual behavior, and then delegated responsibility accordingly. The mothers assessed daughters' competence overtly by inquiring about sexual activity, and knowledge and use of contraceptive methods, and covertly by being vigilant. The informants in this study knew when daughters' menstruation should occur, were sensitive to indicators that they were sexually active, and

attempted to monitor their boyfriends, friends and lifestyles.

Eight of the informants stated that they had suspected that their daughters were pregnant. They noticed the absence of menstruation, and linked symptoms such as vomiting, tiredness, or changes in body shape to the possibility of pregnancy. This phenomenon was also demonstrated in the findings of Bargiow et al. (1968) who studied 78 pregnant girls ranging in age from 11 to 16 years. They reported that in their study, "[t]he pregnancy was diagnosed usually by the girls' mothers, many of whom had been checking monthly to see whether their daughters' menstrual periods had begun" (p. 675).

All of the mothers who suspected pregnancy took action to confirm their suspicions, either by taking the daughters to a physician, or by using a drugstore pregnancy test. These data are in contrast to the findings of Logan (1972) who studied mothers of daughters who delivered and kept their babies. The mothers in her sample stated that they had known that their daughters were pregnant, but waited for the daughters to confide in them. This period, which the author terms the "silent phase" lasted until the daughter was three to four months pregnant, and was significant in that it eliminated the option of abortion. Fischman (1975) found differences in mothers of aborters and deliverers; the aborters' mothers had more education, jobs requiring more skill, and better socio-economic status. Additionally, the

pregnant daughters who delivered tended to have dropped out of school and had a history of poor scholastic performance compared with the aborters who had remained in school and who had better scholastic achievement. Many of the daughters in the present study were described by their mothers as talented girls who were doing well in school and had plans for postsecondary education. It is possible that it is not maternal educational or occupational variables that determine the mother's active or passive response to a suspected pregnancy, but rather the mother's perception of the daughter's achievement potential. Bryan-Logan & Dancy (1974) state that mothers have aspirations for their daughters to attain educational and professional goals that they themselves did not achieve. If pregnancy is seen as a serious threat these ambitions, then there may be a positive relationship between a mother's active response to suspicions of an unwanted adolescent pregnancy and her perception of the daughter's achievement potential. 'Being vigilant' was, therefore, a protective device; through this strategy mothers could allow daughters to accomplish the adolescent task of developing autonomy and separation while keeping a maternal safety net under them. The objective was to prevent pregnancy from interfering with daughters' life options.

Summary

The data from the pre-pregnancy period revealed that the mothers took steps to gain information about daughters' sexual activity and contraceptive efforts. Those that had awareness of daughters' sexual activity had attempted to inform their daughters about the risk of pregnancy and contraceptive methods. The daughters, however, were often resistant to these discussions, and mothers regretted having backed down when the girls protested. The majority of the mothers suspected that the daughters were pregnant without having been told, and intervened to confirm their suspicions.

Hypotheses Generated From the Data

Hypotheses generated from data describing the pre-pregnancy period include the following:

1. Mother's beliefs that daughters may be sexually active positively influences the likelihood that they will seek evidence of this behavior.
2. The degree to which mothers have evidence that daughters are sexually active positively influences the likelihood that they will inform daughters about sexual topics and contraception.
3. As daughters' resistance to mothers' attempts to inform about sexual topics and contraception increases, mothers informing attempts decrease.
4. The more mothers deny that daughters may be sexually

active, the less they will inform about sexual topics and contraception.

5. Mothers' knowledge of daughters' sexual behavior positively influences the likelihood that they will inform about sexual topics and contraception in situation-specific terms rather than in general terms.
6. Mothers' active assistance to daughters in accessing contraceptive methods has a positive relation to the consistency of daughters' contraceptive behavior.
7. Mothers' knowledge of the characteristics of adolescent cognitive development states and the psychological costs of contracepting to adolescents will be positively associated with consistency of daughters' contraceptive behavior.
8. Mothers are covertly vigilant in assessing indicators of daughters' pregnancies, and this activity occurs in a negative relation to mothers' perceptions of daughters' competence as sexually responsible persons.
9. Mothers of daughters who abort will intervene actively to verify suspected pregnancy while the abortion option is open, which differs from mothers of deliverers who will wait to be told that the daughter is pregnant, thus precluding the abortion option.
10. Mothers of aborters have higher estimates of their daughters' achievement potential than will mothers of deliverers.

B. The Pregnancy

Finding Out

The fact that they had suspected the daughters were pregnant, did not prevent the mothers from reacting with strong emotions when pregnancy was finally confirmed. Some reported being shocked, devastated or angry, while others experienced shock reactions later.

> I was devastated when I first heard it, even though I was possibly expecting it. I was hoping to walk into the doctor's office and hear that it wasn't true and...but it was, so I was...like I couldn't say anything, I was so speechless at first.

Pregnancy Resolution Decision-making

Considering the Alternatives

Here, the mothers related how they, the daughter, and others in the family considered the pregnancy in light of the context, that is, how the resolution decision would ultimately affect others, including the fetus. Three alternatives were discussed by the mothers: a) pregnancy continuation with child being relinquished for adoption, b) pregnancy continuation with child being kept, and c) abortion.

Pregnancy continuation with adoption. Adoption was not a consideration for any of the families; either the mother, the daughter or the father was stated to be against this alternative. The fetus was considered as a potential family member who should not be separated from kin:

> We didn't even discuss adoption because it would have never happened. If...we'd have probably gone though the whole role, the interviews, whatever, about being adopted, but when the time came the baby wouldn't have been adopted, because my husband would have said, "That's our grandchild...it can come home with us...it won't go to another home", so we didn't even discuss it.
>
> Well, I just couldn't let myself let her go through the pregnancy and carry the child that long and then have given it up, and her not seeing it and probably me not seeing it and knowing that there's a child out somewhere, and I know that whoever adopted it would love it and take care of it, but still, I felt that there is something out there that belongs to me, to us, to her, and I'd not be able to see it.

One family considered the alternative of pregnancy continuation with adoption for financial reasons, but this option was abandoned when the daughter, herself an adoptee, stated her objections:

> You know, so her dad was with me, of course, and we're all sitting there, and her dad suggested, "Well, you can go through the pregnancy, but we cannot afford to keep the baby..." She [daughter] said, "You know, if I go through this, it is going to be so hard to give it up..."

Pregnancy continuation with child being kept. The mothers stated that this was viewed as a poor alternative for several reasons, the salient one being the adverse effect on the daughter's life options. Most felt that the daughter was not mature enough to provide good mothering for a child, and some mothers were adverse to taking on infant care at their stage in life:

> I hoped that she would make the decision she made. I didn't want to lead her, but I hoped that she would make that decision because although I have a tremendous respect for life, I also felt that at the age of seventeen, she wouldn't be able to provide any kind of a decent life for a youngster, nor would

> it do her any good to have her life changed as drastically as having a baby of her own would...
>
> I would say that no, that would not be an acceptable solution [for mother to take on care of baby], but then I wouldn't know unless I was put in it. I mean, some things you have to accept [laugh] whether you want to or not, but I would not have been prepared to raise a child at my stage in life. That really wouldn't have been acceptable.

Marriage as a solution to the problem was mentioned by one mother who stated that she and her husband emphatically rejected the idea:

> And the only thing my husband and I completely agreed on was that certainly no marriage at that age. That was something we were both adamant about.

Abortion. Ultimately, all the families in this study chose abortion as the best pregnancy resolution decision, however there was considerable variation in the amount of deliberation required and the degree of consensus within the family:

> I felt she had made a mistake, and she was going about it the best way to correct it, and so I was relieved that she was going that way.
>
> ...I, myself did not want the baby knowing who the father was. I did not want any part of that baby, you know [laugh]. Like I told her, "I'll hate it". Maybe ...you know that is the first thing I thought of when she told me: she's having an abortion...when I found out who it was, you know and not only for the reason of that, but I could not see her going through a pregnancy. I just couldn't see it. It was just impossible! Not her, you know? And she's got so much going for her that all I could think of is that it is going to ruin her life, you know.
>
> ...you just hope it was the right one [decision], and in our case, I'm sure it was because I haven't been working except for part-time for the last two and a half years, and money-wise we just do not have what it takes to even do the necessities for a child...

Motners' Involvement in the Resolution Decision

There was considerable variation in the extent to which mothers had input into the choice of abortion as the pregnancy resolution decision. Three informants stated that their daughters had chosen abortion with no alternatives being discussed with the family. These mothers were, therefore, not involved in the decision:

> No, she didn't say she wanted an abortion, she said she was going to have an abortion. So, we were told, not consulted at all, but I can't remember the gist of the conversation, but we agreed that we would pursue that.

> She left us no choice in the matter. She told us right out what she wanted and that was that. We talked and talked to her and tried to change her mind, but there was no way...

In three families, the daughter chose abortion, but alternatives were discussed:

> She had wrote down that she had made her decision, she had expressed that knowing she was only seventeen years old and if I wanted to get a decent job I would have to continue school and who would be left looking after the baby...me and this boy's parents. But she didn't feel it was right to burden...to lay the burden on us because she knew that me and my husband were enjoying ourselves. You know, we'd gone on trips and we could go out in the evenings and didn't have to worry. So then we just discussed it. Um, and she said she didn't want to have the baby and I wasn't for abortion. And, um, then I talked to the doctor and he felt being that she was at that age, that it was best. And, um, then we just went ahead with it.

One informant made the decision that the daughter would have an abortion. Eventually, the daughter was brought to agreement with this choice:

> So, I guess, you know, in her mind, I don't know if she was so confused that she didn't know which way to go, you know, should she go with it or should she

> have the abortion? But I guess what really helped her make up her mind was that after we talked to the doctor, I think she knew that I didn't want her to go through with the pregnancy, you know, and she went my way, and mind you, now she says, "I couldn't have gone through it. I want to finish school and I don't want to leave that school that I'm at", she'd of had to leave that school and she wants to go through school and get a good job, you know. She didn't want to be a drop-out. I felt like maybe, I'm really being nasty, dirty, doing this to her, you know, making her have the abortion...well, not making her, but making her decide..."Okay, [daughter], you're going to make this decision because I don't want you to go through this [pregnancy]".

Four informants avocated abortion, but insisted that it be the daughters' decisions:

> Well, I thought it was an awfully big decision for her to be making. I guess I probably felt sorry for her. I hoped that she would make the decision she made. I didn't want to lead her, but I hoped that she would make that decision [to abort]...
>
> ...and then she went to the doctor and found out, and I asked her what she...what her decision was, what she was going to do, and she said that she wanted to have the abortion. So it was her decision, but possibly I prompted her in that direction. She may have thought that I would disapprove until I said that.

One informant and her daughter made the decision together, considering all alternatives:

> ...she asked me what I thought was the best thing to do, and I told her that's what I thought [advocated abortion] and I figured out for myself what's the best for her at her age and this is the decision that we did make. Both of us, between the two of us. She didn't pressure me into it too much...I mean, she told me what she wanted to do, what she would like to do, before she, you know...she didn't press me into it.

One informant stated that the pregnancy resolution decision was made by the whole family:

> [1] ...her whole family was involved, and we just

decided that it was best that she had an abortion.

The Man Involved in the Pregnancy

Most of the mothers expressed their anger at the man involved in the pregnancy. He was often viewed as a predatory male who had taken advantage of the daughter. Most despised him, and hoped the daughter would not see him again. None of the families considered him as part of the context when making the pregnancy resolution decision. He was an outsider:

> My main concern now is that she'll get an ounce of intelligence in her and realize that he's just a bum.

> ...I know it's over with, but I am angry with him...I still am, and he has to do a lot to earn any respect from me, and until he earns that, I really never want to see him. The thing is, he's not mean, he's not nasty, he is actually a kind person, but he's a bum, that's all. Maybe I can explain that: he's not dirty, he's a very clean person, but if he doesn't have to work, or as long as someone will feed him and entertain him and whatever, he's quite happy to live that way. I don't need a son-in-law like that... I know my daughter has learned a lesson, and I think and I'm hoping in a month he won't even exist in her mind.

Three mothers related that they were so angry with the man involved in the pregnancy that they wished they could physically attack him:

> ...you know, to this day if I ever see him, I think I'll have to go beat him up. I mean he's six feet tall, and I'm only five feet tall, but I am still going to beat him up and say, "Why did you hurt her?"

> ...I keep threatening my daughters...every once in a while...maybe I say it twice a day, maybe I don't say it one day, and maybe the next day it's five times a day, but I'm going to punch his teeth in. He

better not cross my path, sort of thing.

Two mothers who did not express anger with the man involved in the pregnancy, saw the pregnancy as mutually caused, or in one case, as a mistake made by two very young adolescents:

> Well, they just had their one year anniversary about a week ago...so very shortly after. It wasn't a casual thing, she's been with him and it didn't break it up. He offered to go to the hospital with her. I don't know if she talked it over with him at all. It was my feeling that it was totally her decision.

> ...the boy that was responsible...he knew, but his parents didn't, and we sort of set the foot down yesterday and told her to talk to him and we thought his parents had the right to know what happened as well, and so he finally talked to his mother last night, and I guess she was happy to hear about it, you know, that she was told, but she seems to think as well, that the right thing was done because of their ages. The boy is only sixteen.

Daughter's Father or the Man in Mother's Life

These men were seen by the mothers as being a very influential part of the context. They were described as strongly stating and sometimes enforcing their perspectives about the daughters' pregnancies and resolution decisions. Some mothers stated that they agreed to the abortion decision only because the man was adamant that the pregnancy be resolved in this way. None of the daughters told the man about her pregnancy; in families where he was informed, the mother disclosed this information:

> ...and I told her that we had to talk with Dad and...which she was afraid of. Her dad...I don't know why, but she was afraid to tell her Dad, but then at first she was afraid to tell me as well.

> Well, I'm the one who told him. We were alone at the time, and I told him, and I thought for sure he was going to cry, he was so hurt. When I did tell it to him, he was sitting on the couch, and he jumped right up and he grabbed his chest, and that kind of scared me...I thought: Oh my God, no! But right away, he asked who it was, and that made him madder yet.

In three of the families, the man was not informed of the pregnancy, each for a different reason: 1) mother and daughter both felt that the father would "kick the daughter out of the house", 2) the mother and daughter were living apart from the father, and felt it was inadvisable to inform him, and 3) the daughter's father was dead, but the mother felt that it may adversely affect the man's [mother's primary relationship] attitude toward the daughter if he knew of the pregnancy:

> We wouldn't have done this except that her Dad was so against it, you know, and would have kicked her right out of the house.

> Well, this is the first time I've had to keep something back from him...the very first time. It's not that...I would love to tell him and be honest about it, but I don't think it's fair to [daughter] to tell him because I don't want an added pressure between them...

Fathers' Input Into Pregnancy Resolution Decision

The mothers stated that all the men who knew of the pregnancies advocated abortion, except two; one who thought the daughter should have the baby to "teach her a lesson", and another who suggested pregnancy continuation with the baby being relinquished for adoption. They, too, were reported to have considered the pregnancy in light of the consequences to all concerned, including the fetus:

> We talked about it again for the afternoon when him and I were alone, and he said, "Yeah, it would be kinda nice, you know, to have a grandchild", but that he thinks that it's best for her...she's only fourteen years old.
>
> He [husband] thinks more ahead and what it's going to do in the future to the whole family, actually, 'cause she's still got three and a half years of school, plus a couple years of college, so we could have figured on looking after the baby for at least five years.

Two mothers, when discussing the extent of the man's input into the pregnancy resolution decision, expressed concern that had their daughters continued the pregnancy and kept the child, that their own primary relationship might be threatened:

> ...you are the first one I'm saying it to [and that is] that if she had decided to keep this baby, what would have happened between [man who is mother's primary relationship] and myself in our relationship? Really, I honestly do <u>not</u> know. As strong a relationship as this is, it has been seven years we've been seeing one another, what kind of pressure it would have put on? Would we have been able to see it through? I <u>don't</u> know.
>
> And being my husband felt so much the other way [that daughter should have abortion], I don't know. It might have caused trouble with us [if daughter kept baby], I don't know.

Taking Responsibility

Most of the mothers referred to their daughters as 'babies', 'children', 'youngsters', or 'little girls' throughout the interviews, although some of the daughters were close to eighteen years of age. Perceiving that the daughters were not equipped to resolve the crisis of an unwanted pregnancy unaided, the mothers accepted the problem

as their own, taking responsibility for the situation:

> I guess [I took responsibility] because I still feel that at seventeen, she is still too immature to fully accept the fact of what she is doing, and I still feel that I'm the one that is still making a lot of decisions for her. And I think I'll probably feel that way for a long time.
>
> I just don't want them [daughters] to be hurt and if I accept this responsibility then they're going to be alright. I can handle it, and they can't. That's the way I feel. If I take the responsibility, then she can go on and enjoy the best years of her life and I can cope with it.

Mothers Supporting Daughters

Besides having shared with their daughters the crisis of an unwanted adolescent pregnancy, and having assisted her with the complicated arrangements necessary to access a therapeutic abortion, the mothers were sensitive caregivers, concerned with their daughters' physical and emotional well-being. They comforted by giving emotional support and by providing physical nearness:

> And when she came home from school, she just walked into her room. So we both went in and told her that we did love her [voice breaking] and would stand by her and we thought she made the right decision to terminate the pregnancy.
>
> Finally, one day she...we were alone and she just came out...she did tell me that she was pregnant and we were sitting side by side, and I grabbed her and I hugged her and I told her, "Look, just because this happened, you know, we're going to love you just as much as before..."
>
> The night that she came home from the hospital, she was in my room, eh, and my husband surprisingly said to me, "You should sleep with [daughter] tonight". So I went in and I got into bed and I thought: I'm not going to press it if she doesn't want me here, but surprisingly she did! You know, (laugh) we haven't slept in the same bed in years...since she was a little baby...

Discussion of Findings

Bryan-Logan & Dancy (1974) state that there is a denial phase experienced by the mother, where although the pregnancy is suspected, it cannot actually be perceived as real. Once the pregnancy is diagnosed however, there is a release of emotions. The informants in the present study experienced this phenomenon; they stated that even though they had suspected the pregnancy, when it was confirmed, they still reacted with shock, anger or a feeling of devastation. Some mothers moved immediately to making resolution decisions, and did not experience shock reactions until later.

Taking Responsibility for Pregnancy Resolution

In contrast to the literature which tends not to consider the role of parents as a central variable in adolescent pregnancy resolution decision-making, all the informants except one in this study were very much involved. Like those in Logan's (1972) sample of mothers whose daughters delivered and kept their babies, these mothers accepted the problem as their own and moved quickly into a decision-making phase in order to resolve the crisis of the unwanted pregnancy. The mothers in both samples took responsibility for the situation because they perceived their daughters as too immature to deal with the matter alone, and because they felt somehow partially responsible for the pregnancy. Mothers in both studies wondered where they had failed as parents. Most of the mothers in the

present study ascribed blame for the pregnancy to themselves and external factors such as the boyfriend or a sexually permissive social milieu rather than to the daughter. The daughter was seen as minimally responsible due to her age, and sometimes as the innocent victim of a predatory male.

Positing of the source of the crisis to factors external to the family, such as the boyfriend, may have been functional for crisis resolution. Hill (1958) stated that "[i]f the blame for the stressor can be placed outside the family, the stress may solidify rather than disorganize the family (p. 142). Conversely, however, externalization of the source may serve to perpetuate unrealistic family myths that deny the fact of daughters' sexual activity and need for contraception. As Montgomery (1981) notes, "[t]he destruction of a myth of interaction points directly to problems for which the family must take responsibility" (p. 88). The mothers in this study appeared to be positing the source of the crisis to factors outside the family during the crisis. This was probably a coping mechanism. Later, however, in the post-abortion period, most acknowledged that their daughters were voluntarily sexually active persons.

Taking Responsibility for Longterm Consequences

The informants related how they, the daughter, and others in the family considered the pregnancy in light of the context of significant relationships, that is, how the resolution decision would ultimately affect others, including themselves and the fetus. The abortion decision

was constructed from a perspective of social reality and a consideration of interpersonal relationships rather than concerns with questions of morality. This is consistent with Petchesky's (1984) thesis that women make abortion decisions in a "morality of praxis" (p. 367), that is, a morality of situation which is based upon the social conditions and relationships in their lives rather than on received religious and moral values.

It is noteworthy that none of the families considered the man involved in the pregnancy to be part of the context where decision-making was concerned; in almost all cases, once the pregnancy had been discovered, he became a despised outsider, even in those families where he had been previously accepted. This finding is in contrast to that of Rosen et al., (1982) who sampled 66 pregnant women 13 to 19 years of age who chose abortion. They discovered that 65 percent of the girls' parents were reported to like the putative father, while only 19 percent actively disliked him. In the remaining cases, the man was unknown to the parents. While the informants in the present study expressed their personal anger and dislike of the putative father, his nonstatus in the pregnancy resolution context may have been partially a function of the adolescent girls' developmental state. Hatcher's (1973) pregnant early adolescents (defined as 12 to 15 years) projected blame for the pregnancy onto the boyfriend, making him the villain in the situation. The boyfriends of girls in this age group played no part in

their future thoughts. All the middle adolescents in this study (defined as 15 to 18 years) rejected the boyfriend as well; they anticipated a future permanent relationship with some other man. In the present study, exclusion of the man involved in the pregnancy may have been the result of the mothers' negative sanction and externalization of blame for the situation having been validated by the daughters' rejection of him. The majority of daughters in this study did discontinue the relationship with the man.

Contributing to the Resolution Decision

Rosen et al. (1982) studied the extent of parental impact on teenagers' pregnancy resolution decisions. It should be noted that the girls in their study who chose abortion were required to inform only one parent of their pregnancy, and that all the girls who exercised this option elected to inform their mothers. The researchers categorized the degree of parental influence into four divisions: a) direct pressure (defined as potential or actual use of resources in order to gain compliance), 11 percent of the sample of 66 aborters, b) indirect pressure (girls' anticipation that resources may be used as a weapon), 55 percent, c) direct influence (the perspective that the girl should make the ultimate decision and that the influencer is willing to facilitate all options), 24 percent, and d) indirect influence (situational factors such as parental modeling of teenage pregnancy by the mothers or conflicts with parents where independence is asserted), zero percent.

No obvious parental influence was found in 11 percent of the girls who chose abortion. The present study corroborates the research cited above in the finding of considerable parental influence in resolution decisions. While comparison of the two studies is difficult due to the differing methodology and subjects, utilizing an adaptation of the categories of the Rosen et al. (1982) study to adjust from daughters' to mothers' perspectives, parental influence in the present research was related by the informants to be: a) direct pressure, one informant, b) indirect pressure, four informants, c) direct influence, five informants, and indirect influence, none of the informants. Three of the informants stated that there was no parental influence on their daughters' resolution decisions.

It is important to reiterate that the finding of significant parental influence on daughters' resolution decisions is not synonymous with a parental push toward a particular resolution decision. As illustration, five mothers in this study required that the daughter make the ultimate choice. Mothers in this group were influential in that by their willingness to extend resources to facilitate whatever option daughters chose, they did not restrict the choice to abortion.

The informants in this study related the extent of their own impact on their daughters' resolution decision, however the mothers were themselves greatly influenced by the men in their lives, all but two of whom advocated

abortion. Where the mother did not agree with the man's resolution recommendation, she often acceded in the interest of preserving harmony. The results of this study suggest that the man in the mother's life is a very influential part of the decision-making equation, whether or not he is aware of the pregnancy. Daughters' reluctance to inform their fathers of the pregnancy was demonstrated in this study, and the findings of several authors, among them (Barglow et al. 1968; Glasser & Pasnau, 1975; Rosen et al., 1982). None of the daughters in the present study told the father about the pregnancy; in families where he was informed, it was the mother who disclosed this information.

Summary

When pregnancy was confirmed, the mothers were shocked, devastated or angry, but moved quickly to consider alternatives of how the unwanted pregnancy could best be resolved. The mothers took responsibility for supporting the daughter, for resolving the pregnancy, for a variable degree of contribution to the decision to choose abortion, and for the effects of the decision upon the context of salient relationships. This context included the fetus, but not the man involved in the pregnancy.

Hypotheses Generated From the Data

Hypotheses generated from the data describing the pregnancy period include the following:

1. To the extent that mothers absolve daughters of responsibility for the pregnancies for reasons of daughters' immaturity, they will accept responsibility for pregnancy resolution, and this is a positive relation.
2. MCFDAs will be more likely to make decisions about daughters' abortions from a morality of situation rather than from a morality based on received religious and/or moral values.
3. The tendency for MCFDAs to consider the man involved in the pregnancy as an outsider to decision-making regarding daughters' abortions is negatively related to daughters' ages.
4. Key determinants of the potential for parental influence on daughters' pregnancy resolution decisions are parental perceptions of resource availability, the effect of the decision upon those in the context, and willingness to facilitate daughters' choices.
5. Adolescent daughters will inform their mothers about their pregnancies more often than they will inform their fathers.

V. RESULTS AND DISCUSSION: ABORTION AND POST-ABORTION PERIODS

In this chapter, the second portion of the results of the study will be presented. The data were comprised of four major topic areas. The informants addressed issues pertaining to: a) events prior to the pregnancy, b) the pregnancy, c) the abortion, and d) events after the abortion. From each of these large categories, several smaller substantive areas emerged. Data from the first two major categories were reported in the previous chapter, and those from the latter two will be reported here. The analysis will be illustrated with examples of similarities and differences in the verbatim statements of the informants. To protect anonymity, identifying characteristics have been removed or altered.

Following the reports of each major section of the data, the concepts emerging from the these data were examined in the light of relevant extant literature, not for the purpose of verification, but rather for comparison, idea generation, and conceptual guidance (Glaser, 1978). Finally, factors isolated from these data were related to others, and these relations declared in the form of directional, testable hypotheses.

A. The Abortion

All of the mothers in this study were facing the reality of abortion for the first time. Most had not seen abortion modeled before, either by relatives or friends, although many stated that their daughters knew girls who had had abortions. Abortion, as a personal experience, was foreign to the informants; an event they had never expected to encounter:

> It happens to other people, like car accidents. I didn't think I would ever have to be confronted with anything like this, but a lot I knew.
>
> I found it very interesting [television program about abortion] and I wanted to see the pros and cons of abortion, never thinking that within six months I'd be going through this with my daughter.

The Mothers' Views on Abortion

All but three mothers expressed their personal opposition to abortion, but felt, nevertheless, that it was the best pregnancy resolution choice for their daughters. Three mothers had pro-choice views, and stated that they were not conflicted by the decision to abort. One mother, who had espoused a pro-choice view prior to her daughter's pregnancy, reversed her stance when confronted with the reality of abortion:

> I think it was the right thing to do, although I'm against abortion...
>
> At first, you know, I wasn't willing to go to that part...for her to have this done. Because, actually, to tell the truth, I don't believe in it [abortion], I never did. So it was quite a decision to have to make on my part.

> ...I think my attitude about abortion has always been what it is right now. I don't think I ever really struggled. If a person is pregnant and wants to do something about it, I think that that right is theirs. I don't think...I have a fairly strong religious belief and background, and that has never entered into it. I've always felt very, very strongly that it is the woman's decision to make. It's her body. She's the one that has to care for the child after it is born. She has to decide if she's capable of going through with this whole thing and I think I've got a simplistic attitude toward it, but very simply, that's what it is and I don't have a whole lot of hangups about it and probably, I've passed this on to my kids.
>
> I think I've changed my attitude over abortion. I've watched shows lately on abortion and I've always just had the attitude that it's a woman's body and she can do what she wants with it and...but I've never had to face it before.

Secrecy

Secrecy about the pregnancy and abortion was a concern of all mothers and daughters. Some made elaborate plans to keep secrecy. Daughters continued on in school, despite feeling ill, some mothers did not seek support for themselves in the interest of maintaining secrecy, and one mother did not stay at the hospital with her daughter in order to appear to be doing nothing unusual:

> No, I didn't want to discuss it with anyone. This town is only about 6000 people, and in fact I wouldn't be surprised if it got around anyway because of the clinic itself, you know, people that work there.
>
> ...there was no way I could discuss <u>this</u> with her [a relative] because most people will condemn you and don't really put themselves in that position of what they would do.
>
> ..I was sorry that I couldn't stay with her the whole time, but we're trying to not let anybody know, and you know, we wanted to carry on as normal

as possible.

Support for the Mothers

The main issue in this category was the conflict between the desire to keep secrecy and the felt need of the mothers to talk to someone:

> She didn't want anybody else to know about it. We respected that. Although it doesn't give me a...what would you say...a someone to talk to about it.
>
> ...we did keep it very much to ourselves, and <u>that</u> was the hard part.
>
> And, she [daughter] asked me not to tell anybody, and I said at the moment that I would agree not to tell anybody because I didn't know what to do, and I realized the next day that I was in shock about the whole thing, and I realized that I really...that I literally did not know which way to turn and I needed to talk to somebody, but I thought that I needed to respect my promise to her.

Husbands were stated to have been a source of support for some women. Others however, felt that they had been supporting both the daughter and the husband, as well as dealing with their own feelings:

> We [mother and her husband] thought it was something we should do together. As far as going through this, it was done together.
>
> When we first found out she was pregnant, she said, "Do we have to tell anybody?", and I said, "Yes, I have to tell your dad because this is something I feel I can't go through alone. I'm going to need some support."
>
> ...he was supportive in that it was sort of, "I know what you're going through, hon, and I know that this is tough, and gee, what's for dinner?" He's that kind of a person, anyway, though. I knew that I'd get somebody that I could lean on to a certain degree.

Some women felt that men could not be a satisfactory source of support in this situation; these women wished they could have talked to a woman about their feelings, especially a woman who had borne children or had gone through the same experience:

> But I think what I thought when they took [daughter] in for the surgery, I think that's when I could have talked to somebody. Really, really, talked to somebody. My husband was there, but I just couldn't tell him what was in my mind. I think only a woman who has children and has had them, you know, I don't think he could understand for a man.

> I think I would have liked to talk to someone who had been through it that could have assured me that...not that I was doing the right thing, but that, "yeah, this too, shall pass, and you will feel...life will be normal again and what you're feeling right now <u>is</u> okay and it <u>is</u> normal. It's okay to feel frustrated and sad about it", and my God, how could this have happened? Where did I let her down? Where did I go wrong? What didn't I do as a mother? All those questions were <u>really</u> difficult to deal with, and I realized after it was over that this wasn't an issue that I had to take up with myself, it was something that had happened that had to be dealt with, it was simple as that. I was questioning very, very, very much, where had I let this kid down? Where had I been a really poor mother? And <u>that</u> would have been helpful...to have somebody say, "Whoa, your thinking is a little screwed up here".

Two mothers stated that they had felt no need for support for themselves, however both these women had previously reported extensive family support:

> I don't know that I felt the need for support. I think <u>she</u> felt the need for support, and maybe because I was supporting her, I didn't feel it myself.

> No, I didn't [feel a need for support], because like I said, we're very, very close and we shared it, we went through it all together, and I guess I was lucky that way.

Consenting for Daughters' Abortions

Because their daughters were under the age of eighteen and not emancipated, each mother in this study gave formal informed consent for her daughter to undergo the abortion procedure. The signing of the consent implicated the mothers in a personal, concrete way, and their varied response reflects their underlying feelings about abortion.

For some mothers, the act of consenting meant that they were helping their daughters; none of the women in this category were conflicted about abortion:

> It [consenting] reinforced for me that I'm here because I want to be here. She is still my daughter and my little girl. I wouldn't want to be anywhere else but here, and I am taking responsibility for her and for her error.

> ...I thought she was doing the right thing, so the right thing for me to do was to sign it. I didn't feel there was any reason I shouldn't, so I didn't feel bad in any way.

Those informants who stated that they believed abortion to be morally wrong, felt that they were now morally compromised as the result of having given consent. One woman stated she felt that all her moral beliefs had crumbled:

> ...abortion is very much against my religious beliefs for one thing, and so I feel that I have to live with something that I did very wrong, giving consent...

> I think that was the point [signing consent] at which I realized that I was doing it and it was something that I was going to have to live with the rest of my life.

Other women, somewhat less conflicted about abortion than those in the previous category, consented for their daughters' sake, but against their own beliefs:

> And so I thought it over, and I didn't want to sign for it because I'm against abortion, but I thought of her age, and she is still going to school, and it wasn't too long in the pregnancy, so I agreed to it and that's how it came about.
>
> I don't care for it [abortion], but this time...when it is necessary...like with elderly ladies, it is, for their health, eh? I was concerned with [daughter's] health. I'm sure that she would have been down and depressed because she didn't want this to happen, but it did, and being as young as she is, she's...I want and she wants to finish her schooling which she needs bad...nowadays. I felt that I was doin' the wrong thing, but for her sake, I done it because I know that in the end it is better for her this way.

One woman felt extremely relieved when signing the consent; signing meant that the abortion was going to happen:

> [when signing the consent] I felt 500,000 tons off my back, that it was finally happening, and that it was going to be over in a couple hours.

Waiting For the Abortion To Take Place

The mothers cited two waiting periods as having been stressful times for them. The first, waiting for TAC approval, caused anxiety for several mothers, and they experienced relief when approval was confirmed:

> The waiting, the waiting. Was she going to be accepted or not?
>
> It was...you know, so hard, but like I said, it's the waiting period; wondering if she was accepted or not. That was the hard part.
>
> ...and I was worried, if she's turned down, what's my husband going to say?

The other waiting period, after TAC approval, but before the abortion took place, was a stressful time for two

mothers who were reluctant about the abortion decision:

> Actually, I guess I was hoping she would change her mind. [laugh] That's what I was doing. Yeah. Kinda hoping my husband would phone up and say, no, he doesn't want to do it, and we won't. That was my reaction, so it was just sitting here waiting for it to happen, I guess.
>
> The night before we were all a little jumpy. We were all very quiet. The way I felt was almost like someone was going to die.

The Day of the Abortion

Reactions at the Hospital

The environment. Virtually all the mothers were taken aback by the admission procedure. They felt vulnerable in the admissions waiting area, which they described as public, stark, impersonal and crowded:

> I felt somewhat like we were being herded around like cattle.
>
> ...there is a lot of people there coming in in the morning, and you feel, well, are they here for the same reason? Do they know why she's here? People are all being admitted, you know? And you don't want anybody to know. And you are wondering, do they know?
>
> ...one of the reasons I found it so tough, like I said, was walking in in the morning and seeing this line of young children, of babies, waiting to have abortions. It just about knocked my teeth out. In fact, I wondered...I said, "Oh, jeepers, this can't all be for the same reason", but I found out as the day went on that, yep, same reason. And from that point on, I really went into a little bit of shock...

The staff. The mothers seemed to expect negative sanction from the nursing staff, and were prepared to protect their daughters should this occur. Reactions to

staff varied from descriptions of "wonderful", to criticism of the nurses for having no compassion, not being motherly, or being "clinical". One mother wished for more contact with the surgeon:

> Even the nurses at the hospital. They were so understanding, they were so nice. You know that they didn't...what I was afraid of when she went in that day, that they'd be nasty to her because I've heard some people say, "You know, that nurse, she was so mean to me because I had this done", and I went in there thinking: don't you dare hurt her or anything, or I'm going to let you have it, I mean this little girl...it was an accident, more or less, and don't you dare do anything to her, but they were so nice.
>
> ...I found that some of the nursing staff could have been...how can I put it...they could have had more compassion. Like, I seen a few girls there that I didn't see any parents with them, and if they were...they could have had more compassion. Like, I realize that these girls are teenagers, they're teenieboppers, and they are having abortions, but well, they choose to work on that unit, and I believe they could show more compassion. And I also believe that after the surgery, that the surgeon could come and speak to the patient, or the parent, or both. That didn't happen.

Two mothers related that they had been impatient for their daughters' discharge from the hospital:

> At one point I found myself getting annoyed because I wanted to go home, and I wanted her to start feeling better so we could get the hell out of there. I was getting to that point...I was really getting antsy to leave. I felt like I'd been there long enough, I'd done my duty, and I wanted to go...

Fears and worries. Many of the mothers related that they had been extremely anxious for their daughters' safety in the operating room. One mother worried that her daughter would be frightened, while another was concerned that her daughter might be unable to conceive again after the abortion:

> I sort of had this fear that the wrath of God was going to come down on me, and maybe she won't come out alive.
>
> I was really worried about her going for the abortion. I thought, what if something goes wrong? [laugh] What if something goes wrong, and they come back and tell me she didn't make it? All these things go through your mind, you know....
>
> There is always a chance, you know, I read stories... there's always a chance that she can never have another one. That was one of my worries.

Mothers' observations of daughters. The mothers were seeking indicators that the daughters had appreciation of what the mothers felt was a very consequential event. They looked for evidence that the daughter "knew what she had done", and was affected by it in some way, perhaps by feeling a loss:

> ...I looked at my daughter, and I feel that she doesn't realize exactly what's happening, but I've had two children, I know what's happening.
>
> When I came back to the room, the nurse had just finished cleaning her up, and she was sobbing. Just sobbing. I wanted to say, "What do you feel?" I wanted to know: did she feel a sense of loss? Well, I would still like to ask this question to her, and I still haven't...does she feel a sense of loss? Being a normal mother, what came out of my mouth was, "Are you in any pain?" And she said, "Yes", and I don't think she was. I think this because when we got home she didn't seem to have pain and she said for supper she wanted Chinese food, so if she was in any discomfort whatsoever, she would never eat.

Some fathers were present with the mother during the daughters' stay in hospital. The informants stated that the men were worried for the daughters' safety, and seemed to be emotionally upset:

> ...he didn't realize that she had gone for the surgery. I didn't say, you know, I just sat there,

> and I started to cry. And when we were having coffee, you know, I told him, I said, "I hope the surgery is going alright", and he just looked at me in utter...it was almost like he wanted to jump up and say "Stop!", too. That was the impression I got. He didn't say it, but, after eighteen years, you know. But then he just said, "I hope everything goes all right".
>
> My husband said all he was worried about was her getting through the surgery without breathing problems. Since this happened, my husband has been doing a lot of drinking, a lot, every day, as a matter of fact, and I had said to him the other day, "I think we'd better have a talk", and the next day he didn't drink, and last night, only one beer. Whether he...he knew I'd noticed the drinking, but maybe this is his way of coping. I know his mother was really, really against abortion and he knew that, because she had talked to him about it. Hopefully someday he'll talk about it...he just takes a long time to sort out his feelings.

The Fetus

Almost all of the mothers were open in their consideration of the fetus. Some said they did not allow themselves to think of it as a baby, and that this was a protection device. Other mothers stated that they felt it best to deal directly with the issue of the fetus, or those feelings might come out later and cause problems:

> ...it's like part of me is gone...and she's my daughter, and I guess you'd consider it my grandchild, eh?
>
> I was just judging the moment they were coming for her and something inside of me was screaming to stop this, but [voice breaks] I knew I couldn't. I kept thinking [crying] this was my grandchild. This is murder. This is murder, you know. I never thought of that in those terms before. What I'm doing is murder. I just kept saying, "It's murder", and I still feel like I left somebody in that hospital and I didn't want to. [sobbing]
>
> There was a member of the family, and there is nothing you can do to bring him back.

> I think myself, the more a person talks about it, so that they are not holding all those uncertain feelings inside, and that it does definitely help. You can have an abortion, but fifteen or ten years later, whatever, I think that in the back of your mind you will always remember, and wonder.

Discussion of Findings

All of the mothers in this study were facing the reality of abortion for the first time, and all but three expressed their personal opposition to abortion. Clearly then, a "morality of praxis" guided their decision to consent for their daughters' abortions. Petchesky (1984) concludes from an analysis of Gilligan's (1982) interviews with aborters that the center of a morality of praxis is the taking of responsibility upon one's self for making a choice which may be inconsistent with one's beliefs or the dominant ideology of the culture, but is correct in light of the social reality and salient relationships. The informants in the present study provided powerful evidence of this phenomenon; most stated that they felt abortion was wrong, but was, nevertheless, the right decision for their daughters. An MCFDA then, constructs an abortion decision in much the same way as do aborters, and because she is not acting in a neutral or impersonal way, the acceptance of responsibility for making the choice has consequences for her 'self'.

Consenting

Because their daughters were minors, the decision to resolve the pregnancy by abortion was predicated on the understanding that the mothers would give formal consent for the procedure. Acting as daughters' agents implicated the mothers in a personal and concrete way, and their varied response reflected their underlying feelings about abortion. This is consistent with literature which demonstrates the 'self' to be an organizing principle in human information processing (Markus, 1977; Rogers, Keuper, & Kirker, 1977). The self-relevant focus was put forth earlier by Rogers (1951) who stated that experiences are processed in three ways: "a) symbolized, perceived and organized into some relationship to the self, b) ignored because there is no perceived relationship to the self-structure, c) denied symbolization or given a distorted symbolization because the experience is inconsistent with the structure of the self (p. 503). All the mothers in this study gave evidence that taking a responsible role in their daughters' abortions had self-relevant meaning, but their processing of the experience differed.

Applying Carl Rogers' (1951) theory to the data, we see that mothers organized the experience into a relationship with the self-structure; those whose self-structures were congruent with role-taking in an abortion situation identified themselves as such, while others were more comfortable in viewing the role of MCFDA as a sub-set of

mothering. According to Rogers, individuals may defend against certain experiences being symbolized accurately. The experience is edited via the mechanisms of denial and distortion to keep it congruent with the self-structure. Some MCFDAs used defense mechanisms such as portraying themselves as having had no choice in the matter, or by viewing themselves as having become anti-abortion as the result of the experience. This is consistent with the findings of Zimmerman (1977) whose sample of aborters also employed these strategies to align the experience with the existing self-structure. MCFDAs have demonstrated that in taking responsibility for consenting for daughters' abortions, they implicate their 'selves' in much the same way that autonomous aborters do, and where the experience is incongruent with their self-structures, they defend against this incongruence by editing the experience. This suggests that the act of consenting for a daughter's abortion is processed in a self-relevant way, resulting in an experience similar to that of choosing to resolve one's own unwanted pregnancy by abortion. One informant lends credence to this hypothesis when she states, "I feel like it was me who had this done".

Seeking Support for Self

Resolving the dialectic between the desire to maintain secrecy about the event versus a recognized need for support for herself was an issue for most of the informants. Abortion derives its meanings from the dominant ideology of

the culture which has evolved in various historical and social contexts. That women take care to maintain secrecy about abortion is evidence that they perceive it to be an act defined as deviant by their culture. As Petchesky (1984) notes, "[a] century of legal and religious condemnation along with the lived reality of abortion as sinister, secret, dirty, and dangerous, inevitably stamps women's "moral sense" of abortion as wrong or deviant" (p. 367). Having chosen to consent for their daughters' abortions from a "morality of praxis" in conflict with the dominant ideology of the day, the informants stated that they knew they and their daughters would be condemned by others. Maintaining secrecy was, therefore, vital.

Almost all the informants revealed that they had experienced a compelling need to talk to somebody about what they were going through, but felt restrained by the necessity of maintaining secrecy. None of the women desired counseling, but rather the opportunity to simply talk about their feelings with a neutral listener; no ratification of the resolution decision was required. This corroborates the assertion of McDonnell (1984) that the talking-out process is crucial to working through an abortion experience, and that the listener need only be a friend. Additionally, the overwhelming need to talk to someone may account for the fact that all the women who were asked to participate in this study agreed readily; many also later thanked the researcher for the opportunity to relate their experience.

Sachdev (1985) surveyed the abortion counseling research to conclude an absence of consensus among investigators on the effectiveness of counseling programs for abortion patient. While this author cites methodological factors such as the discrepant conceptualization of parameters, divergent measurement criteria and other design problems as having contributed to the lack of resolution of this controversy, in fact, the research thrusts may have been inaccurate. As the informants in this study revealed, it is not counseling that is required, but only a listener. Sachdev (1985) discusses the thesis of Zilbergeld (1983) who proposed that counseling is beneficial for those who do not have supportive people to turn to. Zilbergeld argues (*Time*, May 23, 1983, p. 69) that "the chief benefit of therapy seems to come from talking to a sympathetic listener...". This observation is consistent with the findings of this study which demonstrate that MCFDAs, like aborters, feel a need to talk out the experience with an impassionate listener.

Accessing Abortion

In Canada, as the law stands now, abortions may only be performed in accredited or approved hospitals after approval by a therapeutic abortion committee (TAC) that determines that the life or health of the woman is endangered. Nathanson (1985) reviewed the data collected by the Canadian Committee on the Operation of the Abortion Law (COAL) to find strong evidence that physicians' attitudes affect hospital abortion practices, that there is uneven regional

availability of abortion services, and evidence of a profound influence of moral values and professional climate of opinion in the area of practice upon the gate-keeper role of TAC physicians.

Waiting for TAC approval caused considerable anxiety for several informants in this study, and they were relieved when approval was finally granted. Three of the daughters had been initially denied approval by TAC for various reasons, but were eventually accepted. Two of these had made arrangements to attend a free-standing abortion clinic in the United States in the interim. These data would indicate that there exists an anxiety-producing discrepancy between women's felt needs for abortion and their access to it. Some informants greatly resented this, perceiving uncertain access to abortion to be a political intrusion into a family matter.

Perceptions on the Day of the Abortion

The environment. Adler (1979) surveyed the abortion literature to find that the environment in which the abortion takes place has received little attention from researchers. Virtually all the informants in this study made strong statements about the environment which they described as public, stark, impersonal and crowded. Arrangements for the abortion had been made in the privacy of physicians' offices, and great care had been taken by all the families to maintain secrecy about the event. Then, upon admission to hospital, the mother and daughter found themselves in a

waiting room with many others in a group admission procedure. They worried that others would know why they were there and speculated about which of the other women were having abortions that day. What they had felt was a very private, even secretive event in their lives, now appeared open to public scrutiny in an impersonal environment. This had a profound effect on the mothers.

The staff. The mothers seemed to expect negative sanction from the nursing staff, and were prepared to protect their daughters should this occur. This phenomenon has been reported in aborters by several authors, among them LeRoux (1970) and Zimmerman (1977). In those mothers who perceived abortion to be a deviant act, anticipation of negative sanction would be a consistent response. Moreover, their initial negative response to the admission procedure may have left them feeling threatened and defensive. Adler (1979) reviewed the literature on health care providers in abortion facilities to find considerable evidence that nurses may verbally or non-verbally communicate their disapproval of abortion to the patients in their care. Given their emotional state on the day of their daughters' abortions, expectation of disapproval from staff, and a possible defensive attitude, mothers could be expected to be extremely sensitive to the quality of interpersonal treatment by nurses.

Henry (1973) offers the concept of "hypervigilance" (p. 8), which he describes as a behavior characteristic of

relationships where trust is lacking. Persons suspecting that they may be exploited by others are hypervigilant to cues that seem to confirm their suspicions. Additionally, mothers in their protective-supportive role for the daughters, may have been influenced by the girls' reactions in the setting. Hatcher (1976) states that in her study of aborting adolescents, she found that all of them "experienced extreme sensitivity to the hospital environment, their roommates, doctors, and nursing staff" (p. 421). Some informants thought it must be hard for the nurses to work in an abortion facility and praised their care highly, while others, sympathetic to their daughters' situation wished the nurses had been more "motherly". The invasive preoperative preparation procedures (drawing of blood samples and laminaria tent and intravenous insertions) were upsetting for some mothers, most of whom felt their daughters were "little girls" in a situation inappropriate to their age. While they knew these preparations were necessary, their distress about the procedures was sometimes expressed in complaints about how staff carried them out.

A comprehensive understanding of nurse-patient or nurse/parent interaction in the abortion environment cannot be gained from epistemologically flawed linear causal models (Dell, 1982) which focus on unitary dimensions as, for example, studies relating health care providers' treatment to patient outcomes. Watzlawick, Bavelas & Jackson (1967) state that "a phenomenon remains unexplainable as long as

the range of observation is not wide enough to include the context in which the phenomenon occurs" (p. 20). Further, these authors direct the investigator to focus the inquiry on the observable manifestations of relationship, of interaction patterns, the vehicle of which is communication. Until research delivers an account of the "fit" (Dell, 1982) of interaction patterns in the context in which it occurs, there will be little understanding of interpersonal relations in the complex, emotion-laden abortion environment.

Fears and worries. The informants fears and worries centered around the possibility that the daughter might not survive the procedure. This may be partially the result of associating abortion with frightening images of unhygienic backalley butchers. Zimmerman (1977) has shown that women have many fears about abortion. Significant numbers of her sample of aborters thought that "abortion is something unsafe, unclean and frightening" (p. 157). But some mothers felt that by virtue of having given consent for the procedure, they were accountable should "anything happen". One mother feared that God in His wrath might punish her with the daughter's death for consenting.

Mothers' Observations of Daughters. The mothers observed the daughters in the abortion setting, looking for indicators that the daughters had appreciation of what the mothers felt was a very consequential event. They looked for evidence that the daughter "knew what she had done", and was

affected by it in some way, perhaps by feeling a loss. These sought behaviors seemed to be suppositions by the mothers about how they would have reacted to an abortion experience. That the daughters acted otherwise may have been a function of their early and middle adolescent developmental states. Early adolescents deal with pregnancy and abortion experiences with denial, while middle adolescents protect themselves by externalizing responsibility for the situation to others (Hatcher, 1973).

Mothers' Observations of Father. A few fathers did attend at the hospital, and the informants stated their observations of fathers' worries and concern for the daughters. Petchesky (1984) states that "[e]vidence suggests that the relationship of the two parents to a daughter's abortion is not the same and mothers are more likely to be told and more likely to extend sympathetic support" (p. 225). Further, she notes that mother and daughter may be conspirators in the abortion out of fear of the father's wrath, and that "sexual shame and fear associated with abortion for a young teenage girl, it would seem, is deeply locked into parental authority" (p. 226). The fear of the father as authority figure was demonstrated by daughters in this study and others, yet these informants reported that some fathers had been caring and supportive. Given the impact of fathers in this study, and Petchesky's (1984) contention that while fear of parents, particularly fathers, does not deter adolescent girls from engaging in sex, it

does affect contraceptive use and may delay pregnancy reporting, it is clear that future research must address the role of the father in the family dynamics of adolescent sexuality.

The fetus. The fetus was considered as a potential family member by almost all of the families, a conceptualization that allowed them to consider alternatives in light of what life would be like for significant others with or without a baby present. This is what McDonnell (1984) calls the "courageous leap of "letting in" the fetus, of rejecting the idea that it is simply a clump of cells, of taking it into our moral accounting and allowing it to make some claim on our attentions" (p. 53).

Cathecting the fetus, that is, fantasizing about its appearance, sex, or ascribing to it roles such as grandchild, and being aware of the due date, is associated with sense of loss and sadness in several studies of aborters, among them Friedman, Greenspan & Mittleman (1974) and Cobliner et al., (1973). While the majority of mothers acknowledged their regrets about the fetus simultaneously with relief about the abortion, one mother fantasized about the fetus in an extreme way and reported the most severe post-abortion emotional response of all the informants. Cathecting the fetus would appear to have similar consequences in both MCFDAs and aborters.

Summary

All of the mothers were facing the reality of abortion for the first time, and all but three stated their personal opposition to abortion. The mothers felt the need to talk to someone about their feelings, but this conflicted with their desire to keep secrecy about the event. Signing the consent implicated the mothers in a personal, concrete way, and their varied response reflected their underlying feelings about abortion. At the hospital, mothers were sensitive to the environment, staff, daughters' and fathers' responses, and were concerned for daughters' safety.

Hypotheses Generated From the Data

Some relationships appear to exist among the factors which emerged from this portion of the data, suggesting the following hypotheses:

1. The more mothers perceive the MCFDA role as incongruent with their self-structures, the more they will edit the experience through defensive mechanisms such as denial and distortion.
2. MCFDAs will seek opportunities to talk out the abortion experience with listeners outside the nuclear family where this need is not satisfied within the family, and this positive relation is mediated by the degree of commitment to keep secrecy about the event.
3. Perceived difficulty of accessing daughters' abortions is positively related to pre-abortion anxiety levels in

MCFDAs.

4. The degree of privacy accorded mother-daughter dyads in an abortion setting positively influences MCFDAs' favorable evaluation of that environment.
5. Negatively related key determinants influencing the likelihood of MCFDAs' satisfaction with interpersonal treatment in an abortion setting are communication of disapproval by staff, sensitivity to staff behaviors, negative predisposition to abortion, negative response to the setting by the daughter, and negative perceptions of the environment.
6. The more MCFDAs perceive abortion to be frightening or unsafe, the more they will fear for their daughters' safety during the abortion.
7. The more MCFDAs feel conflicted about their decision to consent for daughters' abortions, the more they will fear for daughters' safety during the abortion.
8. Cathecting the fetus is positively associated with negative post-abortion emotional response in MCFDAs.

B. Events After the Abortion

The period immediately following the abortion was a time of reorganization, characterized by the desire for a return to normalcy. This was expressed in a delightful way by one mother:

> And the family is getting back, you know, like...it's like you took a jug and broke it, and now you're gluing it back together. You know? [laugh]

During this time, the mothers attempted to reconcile the abortion, dealt with their feelings about the event, and sought closure. Simultaneously, they reformulated strategies directed toward daughters' pregnancy prevention. This must never happen again:

Reconciling the Abortion

Grieving

Some mothers who said that they were grieving, related this emotion to the fetus. One, however, stated that she had grieved her daughter's 'lost childhood':

> I think you do have to grieve. I feel like it was me who had this done.
>
> Maybe this two weeks of sitting around crying and burying my head under the pillow, maybe that was what I did need, maybe I needed that time to grieve. I couldn't stop myself. I'd jump up and say: this is enough, and instead, I'd be sitting down crying again, so, yeah, I think you have to [grieve], I really, really do. It is like a death, a tragedy...
>
> Well, I have grieved and I'm sure I haven't stopped. I don't dwell on it, but I definitely grieved. I guess I would like to see her grieve a little. Well, she'll never be the same. It doesn't matter if you consider this...she's never going to be the same as what she was, and so her childhood is like ground unceremoniously to a halt...

Relief

The mothers expressed their relief that it is over; the crisis of the unwanted pregnancy is resolved, and their daughters are going to be alright. Their relief is modified by a notation: while the right decision had been made, this must never happen again. They remain opposed to abortion:

> Yeah, it has been very stressful. I'll have to admit, though, that myself, I am relieved. That this part of it is over, which maybe goes against what [laugh] I might feel myself about abortion.
>
> Myself, I just have to get back to some sense of normalcy, if you want to call it that. It is a relief that it's over, that this part's over, and I haven't got the nervous energy to tackle anything else.
>
> Well, I was relieved after it was done, but I feel bad about it because it was a little life. I think it was the right thing to do, although I'm against abortion, but I think it was.

Seeking closure

One mother explicitly described her need to find a way to work through the experience of her daughter's pregnancy and abortion and to bring closure to the event:

> ...I feel some kind of need to write closure to this, and I don't know how to do that. I should feel some sense of relief that it's over with, but there is so much pressure and tension and stress there, that I have not been able to bleed it off effectively...
>
> I am at a loss to know what it is that I need help with. I haven't identified that for myself yet, like I know what it's not...I can tell you what it's not, but I cannot yet tell you what it is. I am going to have to work this through...

Regrouping

Assessing the Outcome

Once the crisis was past, the mothers sought indicators that the daughters had "learned a lesson"; that they had suffered just a little. Opportunities were provided for the daughters to 'talk it out', but often the daughters didn't,

and this was distressing for the mothers. They sought evidence of change as insurance that this won't happen again.

> ...she never really discussed it with us at all, or even let us know what she was feeling about it, and still hasn't. It was like having a wart removed or something, and finding that it was distasteful, but you just got through, so you could carry on and things are still no different in that respect. She hasn't...I thought perhaps there might be some kind of emotional...well maybe some type of release one way or the other, whether it was crying or really happy or...but I don't know there was anything to speak of.
>
> ...but she seems to act as if...just like she did before, only difference now is that she is on the pill.
>
> ...this suffering [that daughter] is going through right now, she is not going to forget for awhile. And that's good! I don't...it bothers me to see her suffering like this, but maybe, in her case, maybe it's a good thing that she is feeling a little bit worse than some. But, that's good...because she has given it a lot of thought, and it has really hit home in her case, so we'll just cross our fingers.
>
> My biggest concern was that she wouldn't consider it serious enough, that she would take it lightly, because it wasn't...it didn't really affect her life all that greatly. That is my concern...that she is not going to understand the seriousness of it.
>
> ...I don't see any changes. I wish I did! [laugh]
>
> It hasn't affected her attitude like I was hoping it would.

Letting Daughter Know Feelings

Two mothers related that they had let their daughters know how the experience had affected them:

> I've let her know what it's done to me, too. I've helped her out, you know, a lot before it. I didn't condemn her. I didn't scream at her. Supported her fully, and I knew what she was going through, as well, and I didn't even really let her know my

> thoughts much until after it was over with and she was feeling better which was yesterday, Wednesday, and then when we had the family discussion, I brought out exactly what I felt and let her and my husband know that I was against it totally, you know, and all it would have taken would have been a word...the only reason I went with her was that's what she wanted...she's only fourteen, and that's what my husband wanted, so...
>
> I can't deny that I have told her that I would not like this, for her to, you know, to make that mistake again.

Post-Abortion Pregnancy Prevention

The mothers expressed their fears that another pregnancy could occur, and discussed strategies for prevention. They are more insistent now about daughters' contraceptive efforts, and because they were right, after all, pregnancy <u>did</u> happen, they feel they can be more assertive. The daughters, who hopefully have learned a lesson, <u>will</u> use contraceptives:

> I don't think she's questioning the pills...she'll go on whatever contraceptive....
>
> You know, she went through this, and this guy that she knew from before...a friend, you know, he phoned her up for a date, and do you know, I did not sleep until she came home. I just could not sleep, I was so afraid. You know, as much as she's told me, "Mom, it won't happen again", you know, I keep thinking: will she be forced into this? Now I am so afraid. I don't want her to go out on a date, but I can't do that to her. It's not fair. I have to let her go out. She is a teenager. But, I keep thinking: Oh my God, will he force her into it and will it happen again?
>
> ...she will be on birth control [pills], and hopefully she will remember to take them. [laugh]
>
> I guess that I just hope she'll be a lot more careful in the future. But we have discussed the idea of an IUD as an alternative, because she wasn't

always exact about taking them [birth control pills] anyway.

Teaching Other Daughters

Two mothers stated that they had used the incident of this daughter's pregnancy as an example to other daughters:

> We immediately told her little sister about it as well, and we figured that this will be sort of a lesson hopefully learned by the youngest daughter. This is why we made sure the youngest knew everything. We didn't hold it from her, but we hope that she will learn from it.

> ...I did insist that we tell her younger sister, and I did that for two reasons: number one...and I told her the reasons...I said, "You will need somebody to talk to. You will need somebody at school that you can lean on a little bit", and she was grateful after, and I said, "number two, this is a learning experience for your sister". It was tremendously good for her...for her younger sister. [daughter] is going to be eighteen next month and she has a sister who will be seventeen this year.....and they [sister and boyfriend] talked about it and decided that she will go on the pill, but that they will wait [to have intercourse] until she's been on it for three months, because she doesn't want to go through what [daughter] did. So there are some good things that come out of something like this.

Response to the Study

The informants in this study said that it had been therapeutic to 'talk out' their experience with their daughters' abortion:

> Well, I think these two talks have done me a lot of good. It was so hard for me to talk. When I said, 'murder', that was the first time I'd said it aloud, and I guess once you say it, you feel better. Then you have to convince yourself you're not [a murderer].

> It helped me to talk. To let somebody else know how we felt about it and what we had to go through.

Instead of keeping it in, it's good to let it out.

I was very grateful that somebody did want to hear about it.

Well, I'd like to thank you for the opportunity to tell somebody about it. It helped me, it really has. It is hard to not have somebody to talk to about something like this, particularly somebody that is understanding about it. I think that was one of the hardest things about going through the whole thing is not having somebody...you know, somebody that you can tell how you're feeling and get some feedback from them.

Informants' Recommendations

Because the mothers had stated their receptivity to telephone interviewing, and that they had appreciated the opportunity to 'talk out' their experience, some informants were asked if they felt a telephone counseling service would be helpful to families involved in this crisis:

It's a marvelous idea. I had to phone to get some information about something sort of related to this problem several months ago, and I spoke to someone who was a delightful, helpful, empathetic, just a really wonderful, warm person to talk to, and when I got off the phone, I felt like someone had taken twenty pounds off my shoulders. I think it would be a wonderful idea. I think it would be a wonderful service. It's because of that fact that nobody knows who's at the end of the phone, and yet someone is giving you some advice...somebody is telling you that "Hey, others have gone through this, you're not alone"...yeah, I think it's a tremendously good idea.

It would be great [telephone counseling], because in so many cases...you know, personally, I find that when I have a problem, I can worry it over, and I think I have come up with what is a viable solution, but what I actually need to come to a viable solution is to talk it through verbally with somebody, and I don't need them to do any more than listen, 'cause in the process of trying to put it into a way that I can verbalize it, I can lead myself to the conclusion. And I think that is

> probably...I can't think that I'm unique in that...it certainly works for me, and just to be able to do that...and maybe that is a role that our Planned Parenthood could be fulfilling.

Discussion of Findings

The period immediately following the abortion was a time of reorganization, characterized by the desire for a return to normalcy. During this time, the mothers attempted to reconcile the abortion, dealt with their feelings about the event, and sought closure. Simultaneously, they reformulated strategies directed toward daughters' pregnancy prevention. This must never happen again.

Reconciling the Abortion

Feeling relief. This was the salient post-abortion emotion for almost all of the mothers, a finding consistent with much of the more recent empirical research on aborters (Gold, Berger, & Andres, 1979; Meikle, 1973; Rutledge, 1985; Zimmerman, 1977). This is not surprising, since the abortion resolved a very distressing event in their lives. Further evidence that the abortion decision-making was based on a morality of praxis are the statements of many mothers who expressed their relief concomitantly with a continued opposition to abortion.

Grieving. Two informants in this study related that they were grieving, but for different reasons. The mother who cathected the fetus so extremely, grieved the death of what she had fantasized to be a little boy. The other mother

grieved for her daughter's lost childhood. McDonnell (1984) believes that grieving is the necessary final stage of reconciling the abortion experience, the healing process which is necessary to emerge whole again. Also, she states that grieving is usually mixed with feelings of relief and does not reflect regret of the decision, but rather the need to mourn the lost pregnancy and potential child. The two informants who stated that they grieved were the two most conflicted by the abortion decision; the mother described above who cathected the fetus, and another who felt morally compromised at consenting for the abortion procedure against her beliefs. Since MCFDAs would be unlikely to mourn daughters' lost pregnancies, it is possible that their grieving would differentiate from aborters' by relating more to cathecting the fetus or moral objection to abortion.

Seeking closure. One informant explicitly, and several other implicitly related the need to reconcile the abortion and bring closure to their experience of the daughters' pregnancies and abortions. This is consistent with a tenet of Roger's (1951) theory that human beings evaluate experiences in light of their self-structure in order to reconcile these factors. In aborters, this phenomenon was demonstrated in Zimmerman's (1977) sample who sought to establish closure of the abortion experience through a process which included making final sense or an overall definition of the abortion decision within the context of the social world. The reconciliation/closure process is seen

as necessary ~~in~~ aborters, for as McDonnell (1984) observes:

> the consequences . . . of not working through the emotions surrounding an abortion, are likely to be problematic later on. "Unfinished business" can surface again years later, often in other life crisis situations. (p. 39).

If she is viewed holistically, that is, not divided against herself, it seems logical that a MCFDA, like an aborter, will engage in cognitive work to achieve reconciliation and closure of her experience of her daughter's abortion.

Regrouping

Assessing the outcome. Two themes are prevalent in the mothers' immediate post-abortion assessment of the effect of the abortion experience on their daughters. The first of these involves the mothers' bewilderment that the daughters have appeared either to have come through the abortion experience without much effect, or else they weren't talking about it. Again, this is most likely a function of the daughters' developmental status: in early and middle adolescence it would be untypical for a teenage woman to deal with an abortion experience directly (Hatcher, 1973).

The second theme in this stage is characterized by a phrase used by many informants; they hoped the daughters had "learned a lesson". Evidence of change or reform was sought as insurance that unwanted pregnancy won't happen again. These mothers were mature women with a wealth of life experience, yet they rated this experience to have been so stressful that they considered it to be among the most difficult, if not the most difficult crisis of their lives.

The psychological energy expenditure required to resolve it left many women feeling drained. Much like the NICU nurses studied by Hutchinson (1984), these mothers reframed the experience to find meaning in what had been a dreadful ordeal; if it could be made useful in some way, then, as one mother stated, "something good [could] come out of something bad". The lesson hopefully learned by the daughters was used as a reinforcement for pregnancy prevention strategies that the mothers resumed immediately in the post-abortion period. Moreover, two of the mothers used the incident of this daughter's pregnancy and abortion as an informing example for other daughters.

The process by which mothers conduct daughters' sexual socialization, protectively guiding them to competence in the adult sexual role, must be seen as interactive and reciprocal, for mothers change concomitantly with daughters. Petchesky (1984) notes the function of pregnancy "as a visible sign of sexual initiation, sexuality as a sign of individual identity" (p 223). By virtue of the fact of the pregnancy (not the abortion), most of the informants emerged from the experience with an enhanced awareness, (but not necessarily acceptance) of their daughters as sexual beings. This barrier to communication having been removed, some mothers in this study stated that their daughters were talking to them more openly post-abortion than before.

Post-abortion pregnancy prevention. Bryan-Logan & Dancy ( ) found that once a mother was confronted with the

irrefutable fact (pregnancy) of a daughter's sexual activity, she seemed compelled to exert her power as a parent by setting limits for the daughter. This may partially explain the post-abortion assertiveness of the informants with regard to daughters' contraceptive plans. Howe (1984) also described this phenomenon of strong insistence on post-abortion contraception in a mother whose daughter had aborted in a free-standing clinic in the United States. The data in the present study seem to suggest that mothers are afraid pregnancy could happen again, and now have the leverage to be more assertive about daughters' contraceptive efforts. They were right after all, pregnancy did occur.

Summary

The post-abortion period was a time of reorganization, characterized by the desire for a return to normalcy. Here, the informants reflected on feelings, sought closure, assessed the outcome for their daughters, and reformed strategies for daughters' pregnancy prevention. The informants stated that it had been therapeutic to 'talk out' their experience with the researcher, and recommended that telephone counseling be available to families assisting an adolescent through an abortion.

Hypotheses Generated From the Data

Hypotheses generated from the data describing the post-abortion period include the following:

1. In MCFDAs, feeling relief in the post-abortion period is positively associated with the degree of distress about the daughters' pregnancies.
2. Grieving in MCFDAs is positively associated with feelings of loss.
3. Enhanced post-abortion recognition of daughters as sexual beings increases the likelihood that mother-daughter communication about sexual topics will be more open than it was before the pregnancy occurred.
4. MCFDAs will be more assertive that daughters will be contraceptors post-abortion than they were before pregnancy occurred.

VI. CONCLUSIONS

A. Limitations of the Study

The study was limited to a convenience sample of thirteen caucasian Canadians selected from a large urban hospital. Due to the *ex post facto* nature of the study, the self-selected informants may have differentially possessed traits or characteristics extraneous to the research problem. As informants participated voluntarily, their responses may not reflect those of all MCFDAs. Additionally, because of the sensitive nature of the topic under study, one cannot preclude the possibility that the informants have given socially desirable responses. Because the daughters and other members of the informants' families were neither seen nor interviewed, there was neither verification of the MCFDAs' statements about these persons, nor the opportunity to observe family interaction. While richer data would have resulted from interviews with other family members, the objective of the study was to discover how the mothers experienced their daughters' abortions. These perceptions are properties of the individual which cannot be ascertained from an analysis of interaction patterns. Further, as the abortions were obtained by undergoing Therapeutic Abortion Committee approval procedures, this sample likely differs from those who obtained daughters' abortions under other circumstances.

Potential drawbacks to the grounded theory method lie chiefly with the reactive effects of the researcher (Chenitz & Swanson, 1986). The interview method used in this study was by nature interactive. Finally, it should be realized that other researchers might have analyzed these data differently. Chenitz (1986) states that "[t]his is the principal limitation of qualitative research" (p. 224).

B. Summary of Findings

The salient discovery about the experience of mothers consenting for daughters' abortions was that the abortion was not an isolated event in the lives of the informants and their daughters, but rather, was part of a comprehensive ongoing process of daughters' sexual socialization for which mothers have accepted responsibility. Glaser (1978) states that the generation of grounded theory occurs around a core category which accounts for a major portion of variation in the observed behaviors. If this core category is processual, that is, incorporates two or more clear, emergent stages, it may be termed a Basic Social Process (BSP). "[A] BSP processes a social or social psychological problem from the point of view of continuing social organization. Irrespective of whether is solves the problem to some degree, it process it" (Glaser, 1978, p. 97).

The core category, to which all other categories in this study related, was the mothers' acceptance of responsibility for socializing daughters into assuming adult

sexual roles, while attempting to protect them from compromising their life options with an unwanted adolescent pregnancy. This process has a mother-defined time dimension which begins at the daughter's birth and continues until consequences for daughter's sexual actions are no longer accepted by the mother, until she sees sufficient indicators of daughter's competence, or until the daughter seizes the responsibility for herself. This fully variable process, accountable for change over time, has been identified as a BSP, and has been termed Conducting Daughters' Sexual Socialization (CDSS).

The core category, CDSS, is comprised of three interrelated phasic processes; apprehending, taking responsibility, and evaluating. The first of these, apprehending, is defined as a process by which a mother perceives or mentally grasps incipient cues that changes, usually in the daughter's developmental status, warrant a re-formation in ideas or strategies employed in CDSS. The bidirectional and contextual influence for change was noted in the last chapter, and the importance of this will be reiterated here, because informants' apprehension of cues for change from several sources, including themselves, was found to be a determinant of CDSS strategies. Further, re-formation of ideas changed the dyadic interaction patterns, for as Bogdan (1984) explains, "the acquisition or modification of an idea--in one or more individuals leads to change in other individuals so that new ideas and new

interactional patterns are evolved" (p. 381).

The second process, taking responsibility, is a broad term which is defined as assuming agency for the consequences of the daughter's actions until she is deemed competent to act for herself. Intervention is a prominent strategy in this process; mothers attempt to compensate for the deficits, developmental, attitudinal, educational, or behavioral, which were judged to be compromising daughters' competence. These deficits are identified through the third interrelated process, evaluating. Here, a mother also integrates and reconciles the events of the CDSS process with her self-system, and considers the effects on those within the context.

Four clear stages in the CDSS process emerged from the data which differentiated and accounted for variations in the informants' behavior, a finding which satisfied one criterion for asserting discovery of a BSP (Glaser, 1978). These four temporal stages, pre-pregnancy, pregnancy, abortion, and post-abortion differed in the CDSS strategies that were employed, and involved changes that influenced behavior in the succeeding stage. That the four stages were indeed, as Glaser (1978) states, "an integrating scheme" (p. 99), which allows accounting for change over time without loosing conceptual grasp of the overall process, was most apparent in that the goal of the purposive action in each stage was the same: to prevent unwanted adolescent pregnancy from compromising daughters' (and others') life options.

The informants operationalized the conceptual constructs of the CDSS process by employing six major strategies, each of which has been discussed earlier. These are, assessing, informing, being vigilant, accessing services, intervening, and re-forming ideas. Figure 1 depicts a summarizing conceptual diagram of the CDSS process.

C. Implications

As the result of this study, the following implications are suggested as approaches to assisting families to prevent or resolve the crisis of an unwanted adolescent pregnancy. Because the problems surrounding this subject are so complex, an interdisciplinary focus is essential.

Family Life Education

The results of this study have demonstrated that mothers take responsibility for the sexual socialization of daughters, a process which includes informing and intervention strategies. The data have indicated that some constraints to the goal of pregnancy prevention are on an interactional level. Other studies have demonstrated that parental cooperation is an important determinant for adolescent contraceptive success. When mothers in this study attempted to inform daughters about sexual topics, they found the daughters unreceptive, a behavior consistent with their cognitive developmental state. Additionally, several

STAGES:	PHASES AND STRATEGIES: APPREHENDING	TAKING RESPONSIBILITY	EVALUATING
1. PRE-PREGNANCY	DAUGHTER AS SEXUALLY ACTIVE -assessing -being vigilant -reforaing ideas	PREGNANCY PREVENTION -assessing -inforaing -being vigilant -accessing services -intervening -re-foraing ideas	DAUGHTER'S COMPETENCE -assessing -being vigilant -re-foraing ideas PREGNANCY RISK -assessing -being vigilant
2. PREGNANCY	THE FACT OF PREGNANCY -assessing -accessing services -re-foraing ideas ALTERNATIVES -assessing -accessing services	FOR RESOLVING THE PREGNANCY -assessing -accessing services -intervening FOR LONGTERM CONSEQUENCES -assessing -intervening	CONSEQUENCES FOR OTHERS -assessing
3. ABORTION	ENVIRONMENT, STAFF, SAFETY -assessing -being vigilant -re-foraing ideas SELF, FETUS, OTHERS -assessing -being vigilant -re-foraing ideas	ACCESSING ABORTION -accessing services -intervening CONSENTING -intervening SUPPORTING DAUGHTER -assessing -intervening	THE EXPERIENCE -assessing -re-foraing ideas RESPONSE OF DAUGHTER, SELF, OTHERS -assessing -being vigilant -re-foraing ideas FETUS -assessing -re-foraing ideas
4. POST-ABORTION	OUTCOMES AND IMPLICATIONS -assessing -being vigilant -re-foraing ideas	PREGNANCY PREVENTION -assessing -inforaing -being vigilant -accessing services -intervening -re-foraing ideas	RECONCILING, SEEKING CLOSURE -assessing -re-foraing ideas SEEKING SIGNS OF CHANGE -assessing -being vigilant FINDING MEANING -assessing -re-foraing ideas

Figure 1: Conducting Daughters' Sexual Socialization

mothers delegated the responsibility to daughters to access and use contraceptive methods, unaware that the psychological costs of contracepting for adolescents would likely preclude success. If mothers are accepting responsibility for assisting daughters to be effective contraceptors, we must equip them with the knowledge they need to accomplish this; this would include providing mothers with information not only about contraceptive techniques, but about adolescent cognitive developmental states as well. Since the problem is an interactional one, program planners may wish to consider mother-daughter, or adult friend-adolescent contraceptive workshops where barriers to communication about sexual topics, including contraception, could be explored, and ways found to circumvent the problems constraining successful contraception for adolescents.

Abortion Health Care Providers

While the adolescent presenting for abortion is clearly the client, professionals caring for her must be aware that the crisis of resolving an unwanted adolescent pregnancy involves significant others in her life, especially her mother. By taking responsibility for resolving the pregnancy, and for consenting for the procedure, the mother has implicated her 'self' in a concrete way; her behavior will reflect this self-relevant focus to her daughter's abortion, that is, she can be expected to respond in a

manner not unlike adult aborters. Additionally, because mothers perceive their daughters to be in a situation inappropriate to their age, they will tend to be protective of the daughters, and possibly distressed about invasive procedures; they may express this distress through criticism of the staff who carried out the procedure. The degree of privacy available in the abortion setting was found to be an important factor influencing mothers' satisfaction with the environment, as was the perception of care-giving as having been 'personalized', rather than 'assembly-line' or task-oriented.

An early or middle adolescent in an abortion setting is an adolescent in crisis, whose response to the situation will be consistent with her cognitive developmental state; her coping mechanisms will include denial and/or blaming others. If mothers are unfamiliar with adolescent coping mechanisms, they may feel that the daughters' responses are inappropriate to the situation.

Many of the problems surrounding client perceptions of inadequate care or poor interpersonal treatment in an abortion setting can be solved with communication techniques. Mothers should be given the opportunity to explore their feelings about the pregnancy, abortion, and stimuli in the abortion environment, and to discover the meanings that these feelings represent. On abortion day, fears for daughters' safety may displace the mothers' need to 'talk out' the abortion experience with a neutral

listener, but nurses should be aware of this need, assess the availability of support mothers have, and make referrals when appropriate. Most importantly, nurses and other professionals should explore personal biases about adolescent pregnancy or abortion which may interfere with establishing a therapeutic helping relationship with abortion clients and their families.

Support for Families

The family is the societal unit where crisis is processed through members' expenditures of time, materials and energy, and at the expense of normalcy or family functioning. Bringing closure and 'getting back to normal' requires that individuals find ways to dissipate a residue of tension, reconcile the experience with the self-structure, and adjust to the changes that have been brought about. The informants in this study had begun their own tasks of closure, and discussed their observations of this process in other family members. The need to 'talk out' the experience was deemed as necessary for closure by many informants, but where a listener was not available within the family, the need for secrecy often prevented them from seeking one elsewhere.

Because the informants in this study had reacted so favorably to relating their experience through telephone interviewing, some informants were asked if telephone counseling would have been beneficial to them, and they

agreed enthusiastically that it would have been, especially since it solved the problem of keeping secrecy. These data would imply, then, that a telephone support system is needed, where persons involved in resolving unwanted pregnancies by abortion could talk out the experience anonymously with a neutral listener.

Directions for Future Research

This study was a beginning look at a previously undescribed social situation. The experience of consenting for a daughter's abortion was found to be only a part of the larger, lengthy process of socializing daughters to assume an adult sexual role. Factors important to the way in which the problem (unwanted adolescent pregnancy) was processed were isolated, related to others, and these relations were then stated in the form of hypotheses. Glaser (1978) states that BSP analysis allows researchers to transcend the boundaries of the unit in which the BSP was discovered by varying it for another unit's properities. Thus, the BSP (Conducting Daughters' Sexual Socialization) discovered in this small unit of informants may, with variations, generalize to other groups of mothers assisting daughters with the resolution of an unwanted pregnancy by abortion. It is hoped that the results of this study will inspire others to extend or revise this grounded theory by subjecting these hypotheses to empirical testing with larger groups.

The centrality of the mothers' influence in outcomes of adolescent daughters' sexual behavior loomed large in this study. Data suggested that mothers' attitudes and interventions are important variables affecting daughters' contraceptive behavior and pregnancy resolution choices. Because of this influence, and mothers' tendency to assume responsibility for the outcomes of daughters' sexual behavior, future research must take an interactional rather than unidimensional approach to the problem of unwanted adolescent pregnancy. While fathers were not the focus of this study, data emerged to demonstrate their influence as a variable affecting mothers' decisions, and daughters' contraception efforts, pregnancy reporting, and pregnancy resolution decisions. It is clear that the relation of family dynamics to outcomes of adolescent sexual behavior warrants investigation. Additionally, valuable insights would be gained from studies similar to this one, conducted with informants of other cultures.

Adler (1979) has noted the lack of research focus on the abortion environment. This is a curious omission considering the sheer numbers of women terminating their pregnancies by abortion. Smith (1982) notes that the fact of numbers alone denotes that abortion constitutes a significant portion of health care for women, and not "an isolated event in the life of a few" (p. 91). Given the uncertainty of continued access to abortion in an ascendant right-wing political climate (Petchesky, 1984),

environmental variables in an abortion setting may have been seen as frills unworthy of research attention. Further, the stigma surrounding abortion ensures that aborters would be unlikely to publically demand a more therapeutic environment where this was seen to be inadequate. Nurses however, from the time of Florence Nightingale, have appreciated the impact of environmental variables on patient outcomes. The results of this study found for the importance of the environment in informants' evaluation of the abortion experience, an implication that this topic should be explored. Further, the issue of interpersonal treatment in an abortion setting must be addressed through designs that would deliver an account of the fit of interaction patterns in the context in which it occurs.

Other explicit directions for future research would include investigation of the differences in anxiety levels between those obtaining abortions in free-standing facilities or in hospital under the present Canadian laws, evaluative research addressing the efficacy of programs designed to involve adults as partners in adolescent pregnancy prevention strategies, and studies that would provide direction about the type of services required to provide support for families dealing with the crisis of unwanted adolescent pregnancy.

D. Conclusion

The factors which were found to describe most of the variation in the experience of MCFDAs during the abortion stage of the CDSS process fit well within Adler's (1979) Social-Psychological Framework for abortion. In this perspective, abortion is viewed as a stress experience which may be defined by those involved as crisis, the reactions to which "must be viewed not only as reactions to abortion per se, but also as reactions to the experience of having had and terminated an unwanted pregnancy" (p. 112). The similarities between response to abortion by adult aborters and MCFDAs are remarkable, suggesting that by 'taking responsibility', MCFDAs implicate their 'selves', and therefore construct, implement, and resolve an abortion decision in much the same manner as do aborters. Following Adler (1979), "[r]esponses to the experience will be a function of the nature and meaning of the pregnancy to the individual woman, her defensive and coping style, and the social environment surrounding the abortion experience" (p. 100), and finally, abortion, like other crises, "holds the potential for psychological maturation for women who master the experience successfully" (p. 113).

Primary prevention of unwanted adolescent pregnancy must be approached from an interactional perspective with apperception of the fact that the sexual socialization of daughters is a lengthy, reciprocal, primarily dyadic process influenced by the culture and dynamics of a complex nexus of

relationships in the environmental context in which it occurs.

The Contribution of Grounded Theory

Use of the Grounded Theory method to explore the previously undescribed experience of mothers consenting for daughters' abortions has allowed the generation of a theory which has "fit" with the data from which it derived, and "grab" (Glaser, 1978). "Grab" means that a grounded theory speaks in a relevant, makes-sense, feels-right way when it offers a construction of the reality of the informants' perceived experience. Ironically, the persuasiveness of a grounded theory is such that it appears to portray clearly evident processes of human interaction, obvious to all through common sense, even where the phenomenon had not previously been described. Such were the results of this study. Nonetheless, these discoveries have advanced knowledge about how the resolution of unwanted adolescent pregnancy by abortion is experienced by one family member, the mother. Hopefully, others will build on these findings to expand theoretical coverage of how abortion is experienced within the context of the family.

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